Kapuskasing Foot Clinic

Name:	***************************************		
Date of birth:			
Address:			
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Phone number home	cell	wark	
1 none number : nome.	CCII.	work:	
Family Doctor:	ŧ	phone:	
Medical Insurance:yes _	no.	The state of the s	***************************************
If yes name of company:			
Policy number:			
Phone number:			
Reason for appointment:			

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Are you currently taking any	medications? If so	please list them:	
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Do you have any medical con	ditions? Have you	ever had any medical conditions?	
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Have you ever had any surger	iest if an bicase its	t utolif.	
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Have you ever fractured any bones, had any sprains?		
	ATEM 6 404444	
Do you have any communicable diseases such as any others?	s HIV/AIDS, Hepatitis, Tuberculosis or	
THE REPORT OF THE PERSON OF TH	PPPMINI LINUMAN APARTAMAN APARTAMANA	
Do you have any allergies?		
- THE STATE OF THE	MINISTER OF THE PROPERTY OF TH	
Do you have a bleeding disorder?	A TOTAL CONTRACTOR OF THE CONT	
I hereby authorise the Chiropodist to perform tre in the assessment of my foot condition. I also un provided is not covered under O.H.I.P. The fee I Extended Health Care Plan.	nderstand that the cost of treatment	
Signature:	Date:	