CONFIDENTIAL PATIENT INFORMATION **DATE:**

FIRST NAME: **MIDDLE NAME:** **LAST NAME:**

ADDRESS: ***APT #:***

CITY: **PROV:** **POSTAL CODE:**

DATE OF BIRTH (D/M/Y): **AGE:** **MALE / FEMALE /_____** **# OF CHILDREN:**

IF MINOR, NAME & CONTACT INFO OF PARENT/GUARDIAN:

NAME: **MOBILE:** **E-MAIL:**
NAME: **MOBILE:** **E-MAIL:**

OCCUPATION: **COMPANY NAME:**

IF STUDENT, NAME OF SCHOOL: **GRADE/YEAR:**

MARITAL STATUS: *M / S / SEP / DIV / Wid / Eng / Com-Law* **VISA / MC #:** **EXP:**

METHOD OF CONTACT: ***PLEASE DISCUSS FREQUENCY & METHOD OF APPOINTMENT REMINDERS – Default: 5d, 3d, 2hrs*** □

HOME: **BEST METHODS OF CONTACT:** □ Home □ Cell □ Work □ e-Mail

CELL:

WORK: **NAME OF FAMILY DR. / PHONE #:**

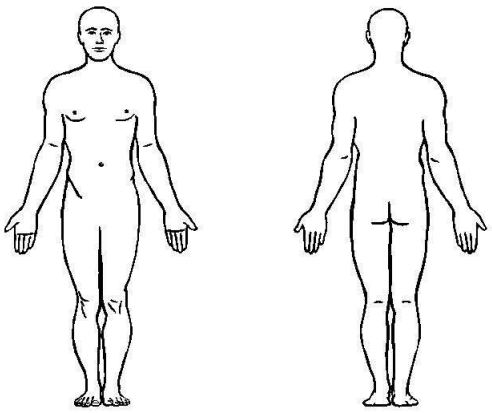
E-MAIL:

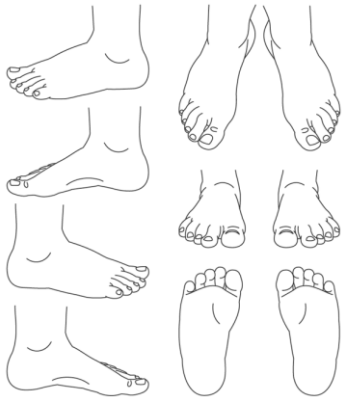
REFERRED BY: □ *LOCATION* □ *SIGN* □ *INTERNET* □ *FRIEND* □ *FAMILY* □ *DOCTOR* □ *OTHER*:
IF BY INTERNET: Search Engine Used: **Word Used:**
IF BY FRIEND/FAMILY, NAME:
IF BY DOCTOR, NAME / ADDRESS:

REASON FOR TODAY'S VISIT: □ BUNIONS □ *CORNS* □ *DIABETIC CARE* □ *NAIL CARE* □ *PAIN* □ *SKIN PROBLEM* □ *WARTS*
□ *ORTHOTICS (NEW / INQUIRY ONLY)* □ *PRESCRIPTION (ORTHOTICS / SHOES)*
□ ***OTHER:***

HOW LONG HAVE YOU HAD THIS CONDITION: **HAVE YOU HAD PREVIOUS CHIROPODY/PODIATRY CARE? Y / N**
IF YES, NAME:

HEALTH QUESTIONNAIRE - *Please MARK and DESCRIBE where you are experiencing problems*





MEASUREMENT / FOOTWEAR & ORTHOTICS: OUTDOORS / INDOORS

Weight	Variety:	Athletic:	Men dress:	Ladies dress:	Indoor footwear:
	□ Blundstones	□ stability	□ Oxfords/Derby	□ flats	□ barefoot
	□ Birkenstocks	□ lightweight	□ Loafer	□ heels: 1" / 2"	□ socks
	□ deck shoes	□ running	□ Dress boots	□ heels: 3' / 4'+	□ Birkenstocks
	□ Converse	□ walking	□ Chelsea boots	□ converse-like	□ Mephisto
Height	□ Vans & like	□ tennis	□ Other:	□ Oxfords	□ Finn Comfort
	□ Toms & like	□ hiking		□ other:	□ Crocs/UGGS
	□ safety boots	□ other:			□ slippers
	□ orthopedic				□ shoes+orthotics
Shoe size	□ diabetic				□ shoes only
	□ other:	**Orthotics:**			□ flip flops
		□ worn 100%	□ worn occasionally	□ worn in the past	□ other:
		□ not worn	□ if not worn, reason:		

HEALTH QUESTIONNAIRE - *Please check off conditions/symptoms which you may have now or have had in the past.*

GENERAL	DIABETES	FOOT ISSUES	JOINT-MUSCLE PAIN
□ Allergies, list:	□ Onset:	□ Athlete's foot	□ Ankle pain R / L
□ Asthma	□ Controlled by:	□ Bunions	□ Lower leg pain R / L
□ Arthritis: OA / RA / Psor	□ Diet	□ Who in family:	□ Knee pain R / L
□ Blood pressure: low/high (N:<130/80)	□ Medications	□ Callus	□ Hip pain R / L
□ Cancer, describe:	□ Insulin	□ Corns	□ Back pain
□ Cholesterol problem (N: <2.0mmol/L)	□ History of ulcers	□ Ingrown nails	□ Neck pain
□ Depression	□ Y / N	□ Fungal nails	□ Scoliosis
□ Eczema	□ Location:	□ Flat arches	□ Sciatica
□ Hearing problem	□ Orthotics worn?	□ High arches	□ Fibromyalgia
□ HIV+ / AIDS	□ Y / N / sometimes	□ In-toeing	□ Previous injuries:
□ Psoriasis	□ Supportive shoes?	□ Out-toeing	□ car accident / MVA
□ Reynaud's' syndrome	□ Y / N / sometimes	□ Warts	□ ankle sprains
□ Swelling of ankles	□ Family history	□ Heel pain R / L	□ fractures
□ Thyroid, describe:	□ Y / N	□ Big toe pain R / L	□ slips
□ Veins: varicose / spider	□ Whom:	□ Arch pain: R / L	□ falls
□ Vision, describe:	□ Blood sugar level: (N: 4.0-7.0mmol/L)	□ Ball of foot pain: R / L	□ other:
□ Other:	□ Your latest reading:	□ Other:	□ Other:

LIFESTYLE QUESTIONNAIRE

SPORTS / EXERCISE	SMOKING	DRINKING	SURGICAL HISTORY
□ Do you exercise? Y / N	□ Do you smoke? Y / N / Never / Socially	□ Do you drink? Y / N / Socially	□ Hip replac't: R / L
□ Days / week:	□ Quit date:		□ Knee replac't: R / L
□ Days / month:	□ Pack / day:		□ Bunionectomy: R / L
□ Type of exercise:	□ Number of years:		□ Other:

MEDICATIONS PRESENTLY TAKEN:

INFORMED CONSENT TO CHIROPODY TREATMENT / VISIT

I hereby <u>request and consent</u> to Chiropody treatment on me by the Chiropodist and/or anyone in the clinic authorized by the Chiropodist including, but not limited to:

- ***various modes of physical therapy (low volt/interferential, therapeutic ultrasound, laser, shockwave, ART, FMT, Acupuncture, etc.),***
- ***local anaesthesia,***
- ***conservative or surgical nail treatments for ingrown or fungal conditions,***
- ***custom orthotics (casting with 3D laser scan or foam box),***
- ***various wart treatments, etc.***

I understand that I will have an opportunity to <u>discuss and understand</u> the nature and purpose of any procedures with the Chiropodist and/or with other clinic personnel <u>before</u> any treatment is performed.
I understand that results are not guaranteed.

I understand that there are some associated <u>risks</u> to treatments, including, but not limited to pain, swelling and infection.
The Chiropodist cannot be held responsible for any unforeseen risks or complications that may result.

I wish to rely on the Chiropodist to exercise judgement during the course of the procedure which the Chiropodist feels at the time, based upon the facts then known, is in my best interest.

I HAVE READ THE ABOVE CONSENT.
I INTEND FOR THIS CONSENT FORM TO COVER THE ENTIRE COURSE OF TREATMENT FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I MAY SEEK TREATMENT.

DATE: ***SIGNATURE OF PATIENT/PARENT/GUARDIAN:***

ACADEMY FOOT & ORTHOTIC CLINICS

www.academyclinics.com **752 Broadview Ave.**
academyclinics@gmail.com **Toronto, ON M4K 2P1**

CHIROPODY FEE SCHEDULE

Initial Visit	**160**
Treatment	**90**
Biomechanical Exam	**120**
Custom Orthotics	**500**
Fungal Nail Laser Treatment	**320**
Laser Wart Removal	**150**
Shockwave Therapy	**180**
Toenail Surgery	**700-900**
Local Anesthesia	**100**
Therapy	
Physical Therapy	**80**
A.R.T – Active Release Therapy	**80**
F.M.T – Foot Mobilization Technique	**80**
Acupuncture	**80**
Swift Wart Treatment	**300**
Nail Bracing	**175**

This is to inform our patients that no part of Chiropody services is covered by OHIP, although these services are covered by most Extended Health Insurance Plans, Department of Veteran Affairs (DVA) and Worker's Safety Insurance Board (WSIB).

Please note:

- **The patient is responsible for any deductibles and co-insurance fees**
- **Payment is due when services are rendered**

I understand and agree to the aforementioned terms and I agree to pay for services rendered.

LATE/CANCELLATION POLICY ***Please read and initial at the bottom***

Our Chiropodists are highly sought after and can only see a number of patients per day. As your appointment is reserved specifically for you, please provide **24** hours notice to cancel or reschedule.

Out of respect for the time of our staff and patients, we will be mailing out an invoice to any client who does not show up or cancels with less than **24** hours notice.

If you arrive late for your appointment, we will try to accommodate you, however, your treatment time may be shortened to maintain clinic schedule. Please expect to be billed for the full cost of the original booking.

Initial ____

_____ _____

Signature **Date**

ACADEMY FOOT & ORTHOTIC CLINICS

INSURANCE INFORMATION

Please fill out the following with your insurance information so the clinic can verify your coverage.

- **Does your spouse have extended Health Care Insurance?**

☐YES, complete below:

		SPOUSE'S INSURANCE	
NAME:		**NAME:**	
D.O.B. d/m/y: *Date of birth*		**D.O.B.** d/m/y: *Date of birth*	
INSURACY COMPANY:		**INSURANCY COMPANY:**	
POLICY GROUP #		**POLICY GROUP #**	
CERTIFICATE ID #		**CERTIFICATE ID #**	
EMPLOYER:		**EMPLOYER:**	

FOR OFFICE USE ONLY

COVERAGE FOR:	**% Covered**	**$ Max**	**Per year**	**Per Visit**	**Deductible**
D.Ch. Visits					
Orthotics					
Orthopedic Shoes ☐OTC ☐Custom Made				Notes:	
Compression Socks					

Gradient:
☐15-20mmHg
☐ 20-30mmHg
☐ >40mmHg

Referred By:
☐ MD
☐ D.Ch.
☐ Other

Orthotic and Shoe Submission Requirements:
Referred By: ☐ MD ☐ D.Ch.
☐ P/up date ☐ Paid in full
☐ Lab invoice ☐ Biomechanical Exam
☐ Assignment of benefits ☐ Make/Model of shoe

Date Called:	Rep's Name

Insurance Billing Address: _____
_____