Sheldon H. Nadal, D.P.M.
586 Eglinton Avenue East Suite 501
Toronto, ON M4P 1P2

TEL: 416-486-9917
FAX: 416-486-9617
www.footcare.net

NEW PATIENT FORM PERSONAL INFORMATION

NAME _____
(LAST) (FIRST) (MIDDLE)

DATE OF BIRTH _____/_____/_____ **AGE** _____
dd mm yyyy

OHIP # _____ **EXPIRY DATE** _____

RESIDENTIAL ADDRESS

_____
STREET # STREET NAME APT/UNIT #

_____
CITY PROVINCE POSTAL CODE

EMAIL _____ **HOME TELEPHONE # (_____)**_____

PLACE OF EMPLOYMENT _____

BUSINESS ADDRESS

_____
STREET # STREET NAME UNIT #

_____ (_____)_____
CITY POSTAL CODE BUSINESS PHONE #

FAMILY PHYSICIAN _____
TITLE FIRST NAME LAST NAME

_____
STREET # STREET NAME UNIT #

_____
CITY PROVINCE POSTAL CODE

(_____)_____ (_____)_____
PHYSICIAN TELEPHONE # PHYSICIAN FAX #

I understand that a podiatrist is not a Medical Doctor (M.D.). He is a doctor of Podiatric Medicine (D.P.M.). Consequently, podiatry fees are not totally covered by OHIP.

SIGNATURE _____ **DATE** _____/_____/_____
PATIENT dd mm yyyy

SIGNATURE OF PARENT/GUARDIAN _____
(IF PATIENT IS UNDER THE AGE OF MAJORITY)

NAME OF PARENT/GUARDIAN_____
(PLEASE PRINT)

FILE # _____
FOR OFFICE USE ONLY

PLEASE COMPLETE BOTH SIDES OF THIS FORM-THANK YOU!

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NEW PATIENT FORM MEDICAL INFORMATION

1. How is your general health? **GOOD** **FAIR** **POOR**

2. Are you now or have you been under a Doctor's care during the past two years?
YES **NO**
If yes, please list Doctor's name: _____

3. Are you taking any medications at this time? **YES** **NO**

If yes, please list medications:_____

_____

4. Have you ever been to a podiatrist before? **YES** **NO**

5. Have you ever had or been treated for any of the following?

	YES	NO		YES	NO
Diabetes			Difficulty in healing		
Stomach ulcer			Epilepsy		
Rheumatic fever			Tuberculosis		
Shortness of breath			Kidney problems		
High/low blood pressure			Liver problems/hepatitis		
Gout			Anemia		
Any heart trouble			Stroke		
Leg cramps			Phlebitits or blood clot		
Drug abuse			Sexually transmitted diseases		
Arthritis					

6. Have you been tested for HIV/AIDS? **YES** **NO**

7. Are you allergic to any of the following?

	YES	NO		YES	NO
Penicillin			Cortisone		
Novocaine			Any antibiotic		
Aspirin			Codeine		
Tape			Latex		
Other medications					

If other medications, please list: _____

8. Are you subject to prolonged bleeding? **YES** **NO**

9. Is there any family history of diabetes? **YES** **NO**

10. I would like the podiatrist to take care of: (PLEASE LIST ALL FOOT PROBLEMS)
_____

_____

11. Who may we thank for referring you to this office:
MacLean's Chatelaine PATIENT _____

DR _____ OTHER _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM-THANK YOU!