Foot & Orthotic Clinic

PERSONAL INFORMATION:

Last Name: _____ First Name: _____

Weight: _____ Shoe size: _____

REASON FOR VISIT: (Please check all that apply)

- ❑ Difficulty cutting toenails
- ❑ Ingrown toenail
- ❑ Corns
- ❑ Callus
- ❑ Warts
- ❑ Orthotics
- ❑ Shoes
- ❑ Flat feet
- ❑ Heel or Arch pain
- ❑ Bunions
- ❑ Foot pain
- ❑ Compression stockings
- ❑ Diabetic foot care
- ❑ Lower back pain
- ❑ Knee pain

❑ Other (specify): _____

Did any Doctor refer you to our clinic?

Dr. Referral Name:_____

MEDICAL INFORMATION:

Health Conditions: _____

Current Medications: _____

Drug Allergies: _____

INSURANCE INFORMATION:

Do you have extended health insurance? (i.e. coverage for Podiatrist/Chiropodist/ Footcare)

❑ Yes ❑ No

Name of Insurance Company: _____ Policy # _____

Chiropody treatment is not covered by OHIP.
The fees are reimbursed by most extended health insurance plans*

I understand that professional fees are payable at time of service (unless other arrangements have been made). Insurance reimbursement is my responsibility. There are no refunds on custom-made or special order items including orthotics and footwear.

_____ _____

Patient's Signature / Parent Date