



# Foot & Orthotic Clinic

## PERSONAL INFORMATION:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Weight: \_\_\_\_\_ Shoe size: \_\_\_\_\_

## REASON FOR VISIT: (Please check all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Difficulty cutting toenails | <input type="checkbox"/> Orthotics         | <input type="checkbox"/> Foot pain             |
| <input type="checkbox"/> Ingrown toenail             | <input type="checkbox"/> Shoes             | <input type="checkbox"/> Compression stockings |
| <input type="checkbox"/> Corns                       | <input type="checkbox"/> Flat feet         | <input type="checkbox"/> Diabetic foot care    |
| <input type="checkbox"/> Callus                      | <input type="checkbox"/> Heel or Arch pain | <input type="checkbox"/> Lower back pain       |
| <input type="checkbox"/> Warts                       | <input type="checkbox"/> Bunions           | <input type="checkbox"/> 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