LMC CHIROPODY & FOOT CARE

SECTION A	**PATIENT REGISTRATION FORM (PLEASE PRINT)**			
First name	**Middle name**	**Last name**	**Birth date (dd/mm/yyyy)**	

SECTION B	**BENEFITS COVERAGE INFORMATION**			
Do you have any extra drug plans or other benefits through work or government? ❑ Yes (Please specify below) ❑ No				
❑ Ontario Drug Benefits (ODB)	❑ Trillium Drug Program	❑ Manulife	❑ Great-West Life	❑ Other
❑ Standard Life	❑ Blue Cross	❑ Sunlife	❑ Desjardins	
Plan #		**Policy #**		

Primary Insurance	**Secondary Insurance**
Subscriber	**Subscriber**
Relation: ❑ Self ❑ Spouse ❑ Other	**Relation: ❑ Self ❑ Spouse ❑ Other:**
Policy/ Plan# Division/ Sect. #	**Policy/ Plan# Division/ Sect. #**
Certificate #	**Certificate #**
ID#	**ID#:**

Method of payment: ❑ Cash ❑ Visa ❑ Mastercard ❑ Other

How did you first hear about our office?

❑ Internet ❑ Yellow pages/ Newspaper ❑ Friend/family/colleague:_____

❑ Health care professional:_____ ❑ Other:_____

SECTION C	**FOOT RELATED QUESTIONS:**		
Your foot problems involve: ❑ Right Foot Only ❑ Left Foot Only ❑ Both Feet			
Why are you here today, explain your current foot problem(s):_____			
Is this problem getting?: ❑ worse ❑ better ❑ same		**Have you had medical treatment for this problem?** ❑ Yes ❑ No	
Have you ever been treated for: (check all that apply)			
❑ Back pain ❑ Warts ❑ Heel pain ❑ High arched feet ❑ Corns ❑ Callouses ❑ Bunions	❑ Hammertoes ❑ Gout ❑ Broken foot/leg bones ❑ Flat feet ❑ Ankle injury ❑ Neuroma ❑ Knee pain	❑ Ingrown nails ❑ Childhood Foot Problems ❑ Other: **If you've had foot x-rays when were they taken?** _____	
What is your current?:	Height:	Weight:	Shoe Size:
On average how much are you on your feet? ❑ 20% ❑ 40% ❑ 60% ❑ 80% ❑ 100%			
What type of footwear do you wear most for work or leisure? ❑ Safety shoe/boot ❑ Athletic ❑ Dress ❑ Sandal ❑ Other_____ **Do you currently use orthotics (shoe inserts)?** _____			
Check any sports or activities you participate in regularly:			
❑ Walking ❑ Aerobics/Aqua Fit ❑ Hockey	❑ Racquet Sports ❑ Running ❑ Golf	❑ Soccer ❑ Skiing ❑ Other:	
Please answer the following questions: Do you have or have you ever been treated for: (Check all that apply)			
❑ Diabetes: ❑ Type 1 ❑ Type 2 How Long? _____ ❑ Heart Trouble	❑ Skin Disorder ❑ Thyroid Problem ❑ HIV/AIDS	❑ Bone Disease ❑ Arthritis ❑ Epilepsy	

❑ Hepatitis ❑ Liver Disease ❑ Urinary Problem ❑ Stroke	❑ Blood Disease ❑ Stomach/Bowel Trouble ❑ Anxiety	❑ Tuberculosis ❑ Other: _____

SECTION D **CONSENT FORMS**

Patient's Consent:

❑ I hereby consent to examination and treatment by the Chiropodist and/or support staff, also to allow photographs of treatment areas to be taken for the purposes of monitoring.
❑ I consent/allow the Chiropodist to contact my physician for any pertinent information required relating to my treatment or medical information.
❑ I consent/allow the Chiropodist to send my physician or health care professional a report regarding my foot exam and treatment plan.
❑ I hereby request and consent to the performance of a chiropody examination and other chiropody procedures, including various modes of palliative care, physical, surgical and orthotic therapy and, if necessary, diagnostic x-rays, on me by the Chiropodist named below and/or anyone working in this clinic authorized by the Chiropodist named below.
❑ I further understand and I am informed that, as in all health care, in the practice of chiropody, there are some very slight risks to treatment including, but not limited to, post-op infections. I do not expect the Chiropodist to be able to anticipate and explain all the risks and complications. I wish to rely on the Chiropodist to exercise judgment during the course of the procedure which the Chiropodist feels at the time, based upon the facts then know, is in my best interests.
❑ I understand that I am financially responsible for all charges whether covered by my health insurance plan or not.
❑ I understand that service fees are payable at the time service is provided. I understand that Chiropody fees are NOT covered by OHIP.

Patient's Signature (or guardian):	**Date:**
Chiropodist's Signature:	**Date:**

Consent Form

Patient Name _____ Date of birth _____ / _____ / _____ (day) (month) (year)

In accordance with Canadian and Provincial Privacy Legislation, please review & complete the following items:

Health Research – Registry Consent

Your anonymous medical data and lab data may be analyzed in research projects to help us better understand diabetes and other endocrine disorders, effectiveness of medications, education and delivery of healthcare. Your anonymous medical data may contribute to a scientific publication but your name and personal information will always be kept confidential. Depending on eligibility, you may be contacted for lectures, information sessions and/or new research opportunities at LMC Endocrinology Centres. Your decision will not affect your future medical care.
Do you agree to allow these uses of your medical data?
Please check to indicate your agreement ❑ YES ❑ NO

Family Contact Consent

May we release or share medical information and/or your clinic schedule to anyone you identify who is involved in your medical care – eg friend, family member, personal representative, or any other individual of your choice?
Please check if you permit us to share this information with your family ❑ YES ❑ NO

Office Policy

Please note that late cancellations (<24hrs) and missed appointments will be charged to you at $50. Please refer to our welcome letter for more details.
I have read the above policies for LMC Diabetes & Endocrinology.
I fully understand the policies and agree to comply with the terms above.

_____ _____
Print Name Date

_____
Signature