LMC Chiropody & Foot Care

PATIENT REGISTRATION FORM (PLEASE PRINT & ENSURE TO COMPLETE SECTIONS A, B, C, D & E)

A) PATIENT INFORMATION

First Name	Middle Name	Last Name	Birth Date (dd/mm/yyyy)	Gender

Provincial Health Care Coverage (Please show identification of your health care coverage to the registration desk)

◯ OHIP ◯ UHIP (University Health Insurance Plan) ◯ IFH/Medavie Blue Cross
◯ Uninsured (no health care coverage) ◯ Blue Cross (National Defense)

Health Card # (OHIP,RAMQ)	Version Code	Province	Expiry (dd/mm/yyyy)

Address	Apt #	City	Postal Code

Home Phone	Mobile Phone
Work Phone	**Email Address**

Please select your preferred LMC clinic location:

◯ Barrie ◯ Bayview ◯ Brampton ◯ Downtown Toronto ◯ Etobicoke ◯ Oakville ◯ Ottawa ◯ Vaughan

B) CONTACT INFORMATION

Preferred Contact Method

◯ Home ◯ Mobile ◯ Work ◯ Children/Care Giver*

***If selected, please specify Children/Care Giver Contact**

Name: Relationship: Phone:

Preferred Appointment Reminder Contact Method ◯ Email ◯ Text Message ◯ Work ◯ Children/Care Giver*

Emergency Contact #1: Name: Relationship: Phone:

Emergency Contact #2: Name: Relationship: Phone:

C) EXTENDED HEALTH CARE BENEFITS COVERAGE INFORMATION

Please select your Extended Health Care Benefits provider

◯ Desjardins ◯ Sunlife ◯ Canada Life ◯ Other: _____
◯ Blue Cross ◯ Manulife ◯ Green Shield ◯ None

D) ADDITIONAL INFORMATION

Family Physician (Name, Phone Number)

Preferred Pharmacy Location (Phone Number, Fax Number)

Medications

(Please present your current medications list to the receptionist upon the completion of this form for your medical records.)

Referred By

Specialists (Name, Phone Number)

◯ Cardiologist: _____
◯ Nephrologist: _____
◯ Neurologist: _____
◯ Ophthalmologist: _____
◯ Orthopaedic Surgeon: _____
◯ Other: _____

Patient Name	**Birth Date** (dd/mm/yyyy)

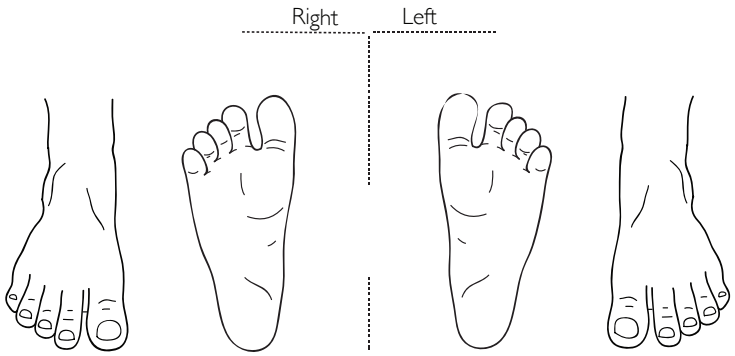
E) FOOT INFORMATION

Please explain your current foot discomfort(s):

This problem is getting:

◯ Worse ◯ Better ◯ Staying the same

Please indicate the area(s) of discomfort(s):



Have you ever had medical treatment for this problem?

◯ Yes

Please Specify: _____

◯ No

Have you ever had foot xrays?

◯ Yes

When?: _____

◯ No

Have you ever been treated for: (Please check all that apply)

◯ Heel Pain/Flat Feet/High Arched Feet
◯ Ankle/Knee/Back Pains or Injuries (broken foot/leg bones)
◯ Ingrown or Fungal Nails
◯ Corns/Callouses
◯ Swelling/Ulcers/Warts
◯ Bunions/Hammertoes
◯ Neuroma
◯ Gout
◯ Childhood Foot History
◯ Other: _____

In a typical day, how often do you find yourself on your feet?

◯ Less than 2 hours
◯ 3 to 4 hours
◯ 5 to 7 hours
◯ 8+ hours

What type of footwear do you wear most often?

◯ Safety Shoe/Boot ◯ Dress/ Heels
◯ Athletic ◯ Sandal ◯ Other: _____

Do you currently (or previously have) use(d) orthotic devices (shoe inserts)**?**

◯ Yes
◯ No

What is your current:

◯ Height: _____ ◯ Shoe Size: _____
◯ Weight: _____

Do you regularly participate in sports or activities?

◯ Yes Please specify: _____
◯ No

Do you have or have you ever been treated for: (Please check all that apply)

◯ Type 1 Diabetes ◯ Bone Disease ◯ Skin Disorder ◯ Stroke
◯ Type 2 Diabetes ◯ Arthritis ◯ Thyroid Problem ◯ Anxiety
◯ Heart Trouble ◯ Hepatitis ◯ HIV/AIDS ◯ Other: _____

Do you have allergies to:

◯ Shellfish ◯ Adhesives/Bandaids
◯ Seasonal ◯ Local Anesthetic
◯ Medications: _____
◯ Other: _____

CONSENT FORM (PLEASE PRINT & ENSURE TO COMPLETE SECTION F & G)

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

F) PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge and agree to:

- Examination and treatment by the Chiropodist and/or support staff, including various physical, surgical and orthotic therapy.
- Allow photographs of treatment areas to be taken for the purposes of monitoring.
- Allow the Chiropodist to contact my physician for any pertinent information required relating to my treatment or medical information.
- Allow the Chiropodist to send my physician or health care professional a report regarding my foot exam and treatment plan.
- I 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, and I understand that service fees are payable at the time service is provided. I understand that Chiropody fees are NOT covered by OHIP.

Print Name	Name and signature if signing on patient's behalf
Signature	Date

LMC Chiropody & Foot Care

COMMUNICATION CONSENT FORM (E-mail, text message & voicemail)

Patient Name	**Birth Date** (dd/mm/yyyy)

RISK OF USING E-MAIL, TEXT MESSAGE OR VOICEMAIL:

LMC Diabetes & Endocrinology offers patients the opportunity to communicate by e-mail, text message or voicemail. Transmitting patient information by e-mail, text message or voicemail, however, has a number of risks that patients should consider before using e-mail, text message or voicemail. These include, but are not limited to, the following risks:

A. E-mail, text message or voicemail can be circulated, forwarded, and stored in numerous paper and electronic files.
B. E-mail, text message or voicemail can be immediately broadcasted worldwide and be received by many intended and unintended recipients.
C. Senders can easily misaddress an e-mail, text messages or voicemail.
D. E-mail, text message or voicemail are easier to falsify than handwritten or signed documents.
E. Backup copies of e-mail, text message or voicemail may exist even after the sender of the recipient has deleted his or her copy.
F. Employer and on-line services have a right to archive and inspect e-mails or text messages transmitted through their systems.
G. E-mail, text message or voicemail can be intercepted, altered, forwarded, or used without authorization or detection.
H. E-mail, text message or voicemail can be used to introduce viruses into computer systems.
I. E-mail, text message or voicemail can be used as evidence in court.

PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge and agree that:

- E-mail, text message or voicemail is not a secure or confidential form of communication. As the message leaves LMC, it is sent across the Internet, where it could be intercepted and read. For this reason, LMC cannot guarantee the security of messages that are sent to and by me.

- Specific issues that will not be discussed via e-mail, text message or voicemail include:
  - Information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse. In addition, the patient is responsible for informing the care provider of any types of information the patient does not want to be sent by e-mail, text message or voicemail.

- E-mail, text message or voicemail will not be used to communicate emergency or urgent health matters, as I understand that:
  - E-mail, text message or voicemail messages can be delayed for both technical reasons and issues relating to the availability of the health practitioner and my condition or the emergency situation cannot be adequately assessed via e-mail, text message or voicemail.

- Clinical decisions about treatment or care may be made on the basis of health information conveyed in e-mail, text message or voicemail.

- Either party may stop communication via e-mail, text message or voicemail at any time if the conditions in this agreement are not adhered to. Notice must be given in writing to the patient or health care provider as applicable, if this form of communication is to stop.

Print Name	Name and signature if signing on patient's behalf
Signature	Date