



**Chiropody services are NOT covered under OHIP
PLEASE REFER TO FEE SCHEDULE ON RECEPTION COUNTER**

Name:	Date of Birth: <div style="text-align: right; font-size: small;">Month/Day/Year</div>
Address:	Phone Number:
City:	Who referred you: <input type="checkbox"/> MD <input type="checkbox"/> Advertising <input type="checkbox"/> Other
Postal Code:	Family Doctors:

PERSONAL HEALTH HISTORY

What is the reason for your visit TODAY?

Nail care Corn/ calluses Diabetic foot screening Wart
 Footwear Orthotics Sports injury Other: _____

List any medical problems that other doctors have diagnosed

Skin Ears, Nose, Throat Head/Neck Heart Problems Stroke Vascular Disease
 Lung Disease Arthritis High Blood Pressure / Cholesterol Lungs Diabetes
 Kidney or Liver problems Cancer Osteoporosis Other: _____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Surgeries or hospitalizations. (Any foot-related, circulation or neurological surgeries)

Allergies to medications

FOOT RELATED CONDITIONS
Check if you have, or have had any symptoms in the following areas

<input type="checkbox"/> Knees, Hips, Back Pain	<input type="checkbox"/> Heel or Arch Pain	<input type="checkbox"/> Circulation
<input type="checkbox"/> Ankle Pain	<input type="checkbox"/> Arthritis in Feet	<input type="checkbox"/> Numb or Tingling Feet
<input type="checkbox"/> General Foot Pain	<input type="checkbox"/> Warts or Other Skin Lesions	<input type="checkbox"/> Infection
<input type="checkbox"/> Toes or Ball of Foot Pain	<input type="checkbox"/> Corns, Calluses, Nails	<input type="checkbox"/> Other: _____

Shoe Size _____

Have you ever had a foot examination before? No Yes (By Who: _____)

How long have you had your foot-related condition? _____

What are your expectations today (Reason for your visit) _____

Date: _____

Signature: _____

NOTE TO CLIENT: We need your informed consent. This means that we want you to understand the services we hope to provide to you, the cost involved, and what we do with personal information we obtain about you. If you have a question on any of this, please ask.

OUR PLEDGE TO YOU:

The Chiropractor and staff at this clinic will make every effort to give you the best quality care in a professional and timely fashion.

OFFICE POLICY:

Time is precious: We will do our best to see you at your scheduled appointment time. Therefore, we expect that all patients be on time for their scheduled appointments. In the event that a patient is more than 5 minutes late for a scheduled appointment, the Chiropractor may reschedule your appointment for a later date. This policy is in effect to keep the clinic on time for all patients.

Appointments are precious: In the event that a patient does not show up for a scheduled appointment, a \$25.00 fee will be charged. Patients rescheduling or canceling an appointment must give at least 24 hours notice.

CONSENT FOR THE COST OF OUR SERVICES

A copy of the fee schedule is posted at the reception desk for your convenience. The fees at this clinic are not covered by OHIP. We do not direct bill to third party insurance companies other than: WSIB, DVA, MSB, and NIHB

CONSENT FOR PERSONAL INFORMATION

I understand that to provide me with Chiropractic goods and services, *Rainville Chiropractic Professional Corporation* will collect some personal and medical information about me. *Information may be collected in written form or by audio recording or by video or photographic devices in order to chart your visit or any telephone conversation.*

I have reviewed the *Rainville Chiropractic Professional Corporation* Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policies and they have been answered to my satisfaction.

I understand that only if I check off the following boxes will I receive the following:

- I would like to receive notice when it is time to review whether I need new orthotics and or shoes.
- I would like to receive newsletters and other informational mailings from *Rainville Chiropractic Professional Corporation*.
- I would like to receive notice of promotions and special offers from *Rainville Chiropractic Professional Corporation*.
- I would like to be notified in the event that personal information is sent out of this office.

I hereby give permission to the Chiropractor employed by *Rainville Chiropractic Professional Corporation* to examine and treat my feet by medical orthopedic or minor surgical methods. All information will be kept confidential and will not be released to any person or third person without written consent.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments. I agree to *Rainville Chiropractic Professional Corporation* collecting, using and disclosing personal information about me as set out above and in the *Rainville Chiropractic Professional Corporation's* Privacy Policy.

SIGNATURE: _____

DATE: _____

Print Name: _____