PATIENT INTAKE FORM

Date: _____

Name: _____ Gender: Male Female
Date of Birth: _____ Heath Card __ __ __ __ __ __ __ __ __ __ VC __ __
MMDDYYYY
Address:
_____
City: _____ Postal Code: _____
Home Ph: _____ Cell Ph: _____
E-Mail: _____ Occupation:
_____
***Emergency Contact* Name: _____ Phone:**
_____
Family Physician: _____ City: _____ Phone:
_____
Relevant Medical History:
_____
Allergies:
_____
List of Medications:
_____
Are you diabetic: Yes: Do you have arthritis: Yes:
*****How did you hear of our clinic:***
_____
Reason for today's visit:
_____
Check √ If Applicable:
I have Extended Health Care Coverage Insurance: Name of Provider: _____
Social Services:
I am on: Ontario Works: I am on: Ontario Disability Support Program (ODSP):
ODSP # _____

Important Notice to Our Patients:
I hereby consent to release of my valid Health Card information to Newmarket Foot Centre/York Medical. I understand that by signing I consent to the sharing of my medical information with other York Medical Clinics/Physicians/ Associates/Staff/York Medical Group of physicians/Affiliated health providers for the purposes of providing necessary medical care to myself or to the individual for whom I am signing. The Privacy Policy is available for review at any time and may be accessed from our Head Office.

OHIP does not cover Chiropody services, fees vary by service.
Initial assessment: $98.00
Please speak with our receptionist if you have any questions.

Please initial here: _____