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: $75.00

Please speak with our receptionist if you have any questions.

Please initial here: _____