PATIENT INTAKE FORM

Date: _____

Name: _____ **Gender:** ☐ Male ☐ Female
First Last

Date of Birth: _____ **Heath Card** __ __ __ __ __ __ __ __ __ __ __ __ **VC** __ __
DD MM YY

Address: _____ **City:** _____

Province: _____ **Postal Code:** _____

Home Ph: _____ **Business Ph:** _____

Cell Ph: _____ **E-Mail:** _____

Occupation: _____

Emergency Contact **Name:** _____ **Phone:** _____

Family Physician: _____ **Phone:** _____

Relevant Medical History: _____

Allergies: _____

List of Medications: _____

Are you diabetic: Yes: ☐ **Do you have arthritis: Yes:** ☐

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: $70.00
Please speak with our receptionist if you have any questions.

Please initial here: _____

NEWMARKET
FOOT CENTRE

Consent to Treatment

I, _____ (Initials) hereby give permission to the Chiropodists at Newmarket Foot Centre to examine and treat my feet by medical, orthopaedic or minor surgical methods.

Consent to Share Information

I, _____ (Initials) authorize Newmarket Foot Centre access to my health information from Physicians, family/caregivers, and other professionals / agents within my “circle of care” for the purpose of medical intervention on my behalf. The “circle of care” is defined as any health service professional or agent, including members of community service organizations. I also authorize Newmarket Foot Centre to share health information within my “circle of care” as deemed necessary.

I understand the purpose of sharing my healthcare information and understand that I can refuse to sign this consent form or withdraw my consent at any time.

Patient Name: _____

Patient Signature: _____ Date: _____

Witness Name: _____

Witness Signature: _____ Date: _____