FOOT AND ANKLE WELLNESS CENTRE

Name: ___________________________________ Alberta Health Care#: ______________________ (F/M)

Address: ____

City: ______________________________ Province: ____________ Postal Code: ______________________

Phone Number: (H) _________________________ (W) _______________________ Ext. ________________

Cell ___________________ Birthdate: M _______ D ______ Y _____ Email: __________________________

Family Physician: __________________________ Physician Phone number: _________________________

Address: _____________________________ City: ________________ Province: _____ Postal Code: ________

<u>Insurance Companies we can direct bill with</u>:

Cowan Desjardins Great West Life Industrial Alliance Johnson Inc Johnson Group Inc

Chamber of Commerce CINUP First Canadian Maximum Benefit

Insurance Company ____

Cardholder Full Name __________________________________ Card Holder D.O.B _________________

Group/Policy # ___________________________ Member ID # _________________________________

Other # ____

Secondary Coverage available: Y/N Injury caused by accident: Y/N Service prescribed/referred: Y/N

Allergies: ____

____

Present Medication: ____

____

Medical Conditions: ____

____

Weight: ____________ Height: ____________ Shoe Size: ____________

Were you referred today? Yes/No If yes by whom ____

If no how did you hear about us? Circle Below

Google TV Commercial Sign/Drove Past Rate My MD Radio

Friend/Other (please name person for our referral program) ____________________________________

Do you have Diabetes? Yes/No **Do you have poor circulation: Yes/No**

Have you ever experienced the following:

Heel Pain	Yes/No
Arch Pain	Yes/No
Calve pain	Yes/No
Knee pain	Yes/No
Hip pain	Yes/No
Lower back pain	Yes/No
Tired/sore feet at end of day	Yes/No
Or after standing and walking	Yes/No
Burning feet	Yes/No
Numbness in the feet	Yes/No
Dry skin on feet	Yes/No
Cracks or fissures on feet	Yes/No

What conditions /concerns would you like to address today? ______________________________________

____

Have you had any treatment is the past for present problem? ______________________________________

If so, what was done?____

Have you seen a podiatrist before?____

☐ **Check this box if you DO NOT wish to receive our monthly newsletter via mail.**

WE REQUIRE ALL FOUR INITALS BELOW

****PLEASE NOTE** Only a portion of this visit is covered by Alberta Healthcare; therefore you will be responsible for any fees not covered by Alberta Health Care. Private Insurance may cover these fees, and any other fees incurred once your Alberta Health Care Allotment for Podiatry has been expended. I have read and understood these terms of service. INITIAL: ________________________________**

+++NOTE+++ Patients who are not currently covered by AHC are responsible for ALL fees incurred per visit plus the AHC portion for ALL services. INITIAL______________

****Patients that NOSHOW for their appointments will be BILLED the fee of the original visit that was scheduled. INITIAL: __________________**

Is your visit today related to WCB? Yes/No PLEASE NOTE WE DO NOT REPORT TO WCB All fees incurred for all evaluation and treatments are the responsibility of the patient. If this is a WCB case, then please notify the receptionist as we do not take any WCB cases. Initial: _________________