

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: _____

Insurance Companies we can direct bill with:

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

Chamber of Commerce / CINUP / First Canadian / Maximum Benefit / Blue Cross / Group Health / GroupSource

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: _____**