Welcome To
The Muskoka Foot Clinic

Kim Resmer,B.Sc.(HK),D.Ch.
Chiropodist

Patient Information: *Please Print

Mr. Dr. _____ _____
Mrs. Miss. **(First Name)** **(Surname)**
Ms.

Date of Birth: _____ ____ _____
(month) (day) (year)

Occupation:_____

Phone Number: (____)_____ (____)_____ext:_____
(home) (work)

Address:_____ _____ _____
(mailing) (street) (city/town) (postal code)

*Contact Person:_____ (____)_____
(if applicable) (name) (phone number)

Family Physicians Name:_____

Referred By:_____
How did you hear about us?:_____

Extended Health Insurance / Benefits ❒Yes / ❒ No
Insurance Company Name:_____

What is your Major Complaint (s): _____
_____
_____

Have you had similar conditions in the past? ❒Yes / ❒ No

Have you received treatment for this condition before? ❒Yes / ❒ No
If yes, by whom:_____

Do you presently wear? ❒ Arch Supports ❒ Custom Footwear

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Have you in the past or do you presently suffer from any of the following?
Please Check:

❒Diabetes	❒High Blood Pressure	❒Liver Problems
❒Arthritis	❒Rheumatic Fever	❒Kidney Problems
❒Gout	❒Angina	❒Shortness of Breath
❒Hepatitis	❒Heart Problems	❒Tuberculosis
❒Cancer	❒AIDS or HIV	❒Phlebitis
❒Anemia	❒Difficulty Healing	❒Epilepsy
❒Circulation Problems		❒Thyroid Problems

❒Any Other Health Problems? _____

_____

_____

Are you subject to prolonged bleeding? ❒Yes / ❒ No

Have you had any surgeries? ❒Yes / ❒ No
Please list:_____

_____

Have you broken any bones? ❒Yes / ❒ No
Please list:_____

Are you taking any medications at the present time? ❒Yes / ❒ No
Please list:_____

_____

Do you have any allergies? ❒Yes / ❒ No
Please list:_____

_____

CONSENT:

I hereby consent to treatment by **Kim Resmer**,**B.Sc.(HK),D.Ch.** and the plan and rationale have been fully explained and understood. I also agree that my Chiropody records may be shared by the following individuals:

1.Family Physician
2.Insurance Company
3.Other Health Care Professional

Signature: _____ **Date:**_____