AURORA | FOOT & ANKLE CLINIC

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Langley, BC V1M 4E7

DATE: MO / DA / YR **PATIENT INFORMATION FORM** (PLEASE PRINT)

PATIENT NAME: _____ ____ _____
FIRST MI LAST

GENDER: ☐ M ☐ F ☐ N/B TITLE: ☐ MR ☐ MRS ☐ MS ☐ MISS ☐ JR ☐ DR

HEIGHT (FEET/INCH): _____ WEIGHT (LBS): _____ SHOE SIZE (US): _____

BC CARE CARD #: _____ DATE OF BIRTH: MO / DA / YR AGE: _____

ADDRESS: _____ CITY: _____ POSTAL CODE: _____

MAY WE LEAVE A MESSAGE?

HOME PH #: (_____) _____-_____ ☐YES ☐NO

CELL PH #: (_____) _____-_____ ☐YES ☐NO

E-MAIL: _____ ☐YES ☐NO

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) _____-_____

PRIMARY CARE DOCTOR: _____ CLINIC NAME: _____

HOW DID YOU HEAR ABOUT US? _____

WHAT DO YOU DO FOR WORK (OR OTHER)? _____

ARE YOU ON YOUR FEET AT WORK? ☐YES ☐NO

WHAT TYPE OF SHOE ARE YOU WEARING FOR WORK *OR* WEARING WHEN YOU ARE ON YOUR FEET THE MOST?

☐ RUNNING SHOE ☐ DRESS SHOE (FLATS) ☐ HEEL ☐ STEEL-TOE BOOT/SHOE ☐ OTHER:_____

PERMISSIONS

☐ I GIVE AURORA FOOT & ANKLE CLINIC PERMISSION TO CONTACT ME IN REGARD TO APPOINTMENTS, AND/OR OTHER CORRESPONDENCE BY TEXT OR EMAIL AS INDICATED IN THE ABOVE PATIENT INFORMATION SECTION

☐ I GIVE PERMISSION FOR NON-IDENTIFYING PHOTOS, IF ANY TAKEN, TO BE USED BY AURORA FOOT & ANKLE CLINIC

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ ☐ DAYS ☐ WEEKS ☐ MONTHS ☐ YEARS

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING

☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

0 1 2 3 4 5 6 7 8 9 10*(WORST)*

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

YOUR MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE EITHER **YES** OR **NO**)

ARTHRITIS	Y	N	HEART ATTACK	Y	N	MULTIPLE SCLEROSIS	Y	N
ATRIAL FIBRILLATION	Y	N	HEART DISEASE/FAILURE	Y	N	NEUROPATHY	Y	N
CANCER	Y	N	HEPATITIS	Y	N	PSORIASIS	Y	N
CHEMOTHERAPY	Y	N	HIV+/AIDS	Y	N	RHEUMATOID ARTH.	Y	N
DIABETES (TYPE 1 OR 2)	Y	N	HIGH BLOOD PRESSURE	Y	N	SCIATICA	Y	N
FIBROMYALGIA	Y	N	KIDNEY DISEASE	Y	N	STROKE	Y	N
GOUT	Y	N	LIVER DISEASE	Y	N	THYROID DISEASE	Y	N

OTHER MEDICAL CONDITIONS: _____

PLEASE LIST ALL **PRIOR MAJOR SURGERIES/HOSPITALIZATIONS**:

TYPE/REASON	DATE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE LIST ALL **PRESCRIPTION MEDICATIONS** YOU ARE CURRENTLY TAKING:

MEDICATION NAME/DOSE	HOW OFTEN DO YOU TAKE?
_____	
_____	
_____	
_____	
_____	
_____	

ALLERGIES: _____

LIFESTYLE HISTORY

USE OF ALCOHOL: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ OCCASIONAL ☐ WEEKLY ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

EXERCISE: ☐ NEVER ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____

SIGNATURE DATE

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or manager.

- Payment for services and/or devices are due at the time of service. We will accept VISA, MasterCard, American Express, debit or cash. Personal cheques are not accepted.

- There are certain elective procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those.

- For the initial pair of custom orthotics, there is a minimum deposit of 50% of the full purchase cost required at the time of order. For additional pairs, the entire balance is collected at order.

- **ORTHOTICS ARE NOT REFUNDABLE.** As prescription orthotics are custom-made for each patient, they cannot be returned for refund.

- Used medical devices, like splints or braces, cannot be returned for refund unless the product is deemed defective, in which a replacement device may be issued.

- A No Show/Cancellation fee may be charged for any missed appointment or cancellation made with less than 24 hour notice. Payment for visit fee(s), new or follow-up, are also non-refundable.

MSP of BC

- Podiatry is NOT a covered service of Medical Services Plan of BC. Posted fees for services or procedures are exclusive of any MSP reimbursement and are your responsibility to pay.

- Patients who have MSP Premium Assistance may have a subsidy towards appointment fees. MSP will be billed directly by the practitioner for any applicable services or procedures. Any MSP reimbursements will be paid directly to Dr. R J Stanford dba Aurora Foot & Ankle Clinic, Practitioner #52796. You will not be charged the portion that is reimbursable by MSP.

Private/Extended Medical Insurance

- We DO NOT have direct billing access to private medical insurance providers. Therefore, all charges for your care and treatment are due at the time of service. At the time of payment, we provide a receipt which may be used for submission to private insurance. Our rates are the same regardless of insurance coverage or lack thereof. If your extended insurer requires so, you are responsible for all authorizations/referrals needed to seek treatment in this office.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____

Date: _____