

Dr. Royden J. Stanford, BSC, DPM, DABPM

Main: (604) 248-8985
www.aurorafac.com

#4 - 8880 202 Street
Langley, BC V1M 4E7

DATE: Mo / Da / Yr

PATIENT INFORMATION FORM (PLEASE PRINT)

PATIENT NAME: _____
FIRST MI LAST

GENDER: M F N/B TITLE (OPTIONAL): MR MRS MS DR

BC CARE CARD #: _____ DATE OF BIRTH: Mo / Da / Yr AGE: _____

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

ADDRESS: _____ CITY: _____ POSTAL CODE: _____

HOME PH #: (____) ____ - ____ MAY WE LEAVE A MESSAGE? YES NO

CELL PH #: (____) ____ - ____ MAY WE LEAVE A MESSAGE? YES NO

E-MAIL: _____

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

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

PRIMARY CARE DOCTOR: _____ CLINIC NAME: _____

OCCUPATION: _____ STAY AT HOME STUDENT

DO YOU WORK ON YOUR FEET? YES NO OCCASIONALLY

WHAT TYPE OF SHOE ARE YOU WEARING FOR WORK?

ATHLETIC SHOE CASUAL SHOE STEEL-TOE BOOT/ SHOE DRESS/CASUAL BOOT
 SANDAL DRESS SHOE (FLATS) HEEL OTHER: _____

DO YOU WEAR CUSTOM FOOT ORTHOTICS? YES NO I HAVE IN THE PAST

CURRENT PROBLEM

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

HOW LONG HAS THIS BEEN A PROBLEM? (#) _____ DAYS WEEKS MONTHS YEARS

HOW WOULD YOU DESCRIBE YOUR PAIN? NO PAIN ACHING BURNING DULL ITCHING

RADIATING SHARP SHOOTING STABBING TINGLING OTHER: _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

YOUR MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE EITHER **Y**ES OR **N**O)

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

DO YOU DRINK ALCOHOL? YES NO QUIT – HOW LONG AGO? _____

DO YOU SMOKE TOBACCO? YES NO QUIT – HOW LONG AGO? _____

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: _____