*The Hamilton Foot Clinic*

**Patient Intake Form**

**Patient Information**

Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Given Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt/Unit #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone Number #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Version Code \_\_\_\_\_\_\_\_\_ Expiry Date \_\_\_\_\_\_\_\_\_

Date of Birth: Day \_\_\_\_\_\_\_\_\_ Month \_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_ Sex: M \_\_\_\_\_\_\_\_\_ F \_\_\_\_\_\_\_\_\_

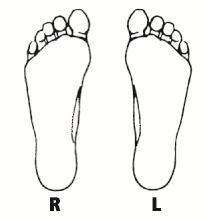
Fam./Refer. Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Location/City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Internet search, advertisement, doctor’s referral, family, friend, coworker,* ***please specify who or where etc****.*)

**Medical Information**

Body Part(s) of Concern: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spacer 12 font text so that this part lines up ------------ *Circle Area*

Date of Injury/Onset of Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe Injury/Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do these symptoms affect your life: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rate Your Pain: (Least) 0 1 2 3 4 5 6 7 8 9 10 (Most)

Past Related Treatments: Physiotherapy Massage Orthotics Bracing (*Bottom of Feet*)

History: Past Surgeries Diabetes (Type I/II) Arthritis Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: Codeine Cortisone Adhesive Tape Bandages Latex Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Shoe Size: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information** ***(For custom-made orthotics and other prescribed devices only)***

*Extended Health Insurance*

|  |  |
| --- | --- |
| Primary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Group/Plan #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I.D./Certificate #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Secondary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Group/Plan #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I.D./Certificate #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Spousal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Spousal Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*Other Health Insurance and Coverages*

WSIB DVA ODSP OW Indian Affairs MVA

Claim/Identification #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **Consent to the Collection, Use and Disclosure of Personal Health Information**

*Note to client: We want your informed consent. We want you to understand what we do with the personal health information we collect about you. Please ensure that you have read and understood our written statement, “Our Privacy Commitment to You”. If you have any questions, please ask.*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that to provide me with Foot Care/Foot Pain/ Orthotic and Foot Rehabilitation services, The Hamilton Foot Clinic and The Foot & Ankle Institute will collect personal information about me (e.g., birth date, home contact information, health history, etc.).

I have reviewed the clinic’s written statement on the collection, use and disclosure of personal health information. I understand how the written statement applies to me. I have been given a chance to ask questions about the clinic’s privacy policies and they have been answered to my satisfaction.

I understand that the clinic will only collect, use or disclose my personal health information with my express or implied consent, unless a collection, use or disclosure without consent is permitted or required by law.

I further authorize The Hamilton Foot Clinic and The Foot & Ankle Institute to collect, use and disclose my personal health information for the following purposes (*indicate your consent by checking the applicable box(es)*):

* to use or disclose your personal health number to verify your identity or to access other personal health records about you in order to provide health care services to you[[1]](#footnote-1)
* to notify me of new services or goods available at the clinic.
* to notify me of special events and opportunities at the clinic. (e.g. a seminar or conference)

I understand that I can withdraw my consent at any time by contacting:Lyne/Kathy

I agree to the clinic collecting, using and disclosing personal health information about me as set out above and in the written statement.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Express consent is not required for this purpose where the individual’s health number has already been collected to provide health care services that are paid by OHIP. [↑](#footnote-ref-1)