The Hamilton Foot Clinic

Patient Intake Form

Patient Information

Surname: ________________________________ Given Name: ________________________________

Home Address: ____ Apt/Unit #: ____________________

City: ____ Postal Code: ____________________________

Primary Phone #: _______________________ Secondary Phone Number #: _______________________

Email Address: ____

Health Card #: _______________________________ Version Code _________ Expiry Date _________

Date of Birth: Day _________ Month _________ Year _________ Sex: M _________ F _________

Family Physician: _______________________________ 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: ____

Date of Injury/Onset of Symptoms: _________________________________

Describe Injury/Symptoms: ____

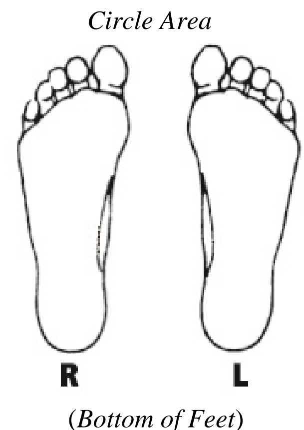
____

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

Circle Area



(*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 #: ____

I understand that the information collected on this form is relevant to the care I will receive from The Hamilton Foot Clinic. I am aware that The Hamilton Foot Clinic has their privacy policy that will be made readily available to me upon request. I agree to The Hamilton Foot Clinic collecting, using and only disclosing my personal information to specific parties as set out in their privacy policy.

Patient Signature: ____ Date: __________________________

COVID-19 (CORONAVIRUS)
HEALTH ASSESSMENT and DECLARATION

The self-declaration form is required in order to safeguard the health and safety of *The Hamilton Foot Clinic* employees and restrict the outbreak in the general population. Please fill out the form to allow us to take steps necessary to protect your health and safety.

I ,____, hereby certify, represent and warrant as follows: Within the **twenty-one (21) days** immediately preceding the Date of this Health Declaration Form, I HAVE NOT:

1. Tested positive or presumptively positive with COVID-19 or been identified as a potential carrier of the COVID-19 virus or similar communicable illness
2. Experienced any symptoms commonly associated with the Coronavirus, including but not limited to: **Fever/feverish, new or existing cough, difficulty breathing, loss of taste or smell.**
3. Travelled outside of Ontario in the last 21 days
    a. If you have, where have you travelled:

    ____

4. Been in close contact with a confirmed or probably COVID-19 case, been in close contact with a person with acute respiratory illness who has been outside Canada in the last 21 days

I AGREE to notify *The Hamilton Foot Clinic* (by email: info@healthyfeet.net) of any change in status, including diagnosis with COVID-19 and/or quarantine, within thirty (30) days following treatment at the clinic.

I WILL wear a mask (of the specifications recommended by the procedure operator) at all times while in the clinic, and will take all reasonable protective steps that may be recommended by the chiropodists and/or staff.

I ACKNOWLEDGE and ACCEPT that this Declaration will be considered as my consent to the *The Hamilton Foot Clinic* to disclose, share, record and store this Declaration with any relevant authority or service provider for the purposes of ensuring the safety and security of any and all third parties that may come in contact with me prior, during, and after any procedure.

________________________________ ____________________________
Signature Date

Thank you for this information and helping us prevent the spread