PATIENT REGISTRATION FORM

	Today's date

PATIENT INFORMATION

Surname of patient	Given name(s) of patient	Date of birth

Age	Gender	Height	Weight	Shoe size
	❑ M ❑ F			

Home address	City	Province	Postal code

Telephone number (daytime)	Telephone number (evening)	Email address

Emergency contact	Phone number of contact	Relationship to patient

If patient is a minor, name of parent / guardian	Telephone number	Address, if different

How did you hear about us?	Name of person who referred you
❑ Friend or family member ❑ Doctor or other medical professional ❑ Internet or our website ❑ Other (please specify):	

Who is your primary or family doctor?	Doctor's telephone number

At which pharmacy do you fill your prescriptions?	Pharmacy's telephone number or location

Occupation	During your workday are you…
	❑ Sitting ❑ Standing ❑ Frequently walking around ❑ Wearing steel-toed shoes

What is the reason for your visit to a podiatrist today?

If injury, is it work-related?	Have you tried any treatments already?
❑ Yes ❑ No	

PERSONAL HEALTH HISTORY

Please list any current and past medical conditions:

Any major surgeries or hospitalizations?	Please explain:
❑ Yes ❑ No	

Sarah Cantin-Langlois, DPM
Podiatrist
255 rue St-Jacques
Montréal, Québec

Please list any medications or supplements you currently take (either prescription or over-the-counter):	
Please list any allergies you have:	
Do you exercise? Please list the type of activity and frequency:	
Do you smoke? ❑ Yes ❑ No	If yes, how many cigarettes or packs per day?
Do you drink alcohol? ❑ Yes ❑ No	If yes, how many drinks per day/week?
Do you wear (or have you worn) orthotics in your shoes? ❑ Yes ❑ No	

TREATMENT AUTHORIZATION

I, the undersigned, do hereby authorize Dr Sarah Cantin-Langlois and her staff to proceed with treatment and/or therapy on me that they consider medically necessary to treat the injury or condition for which I am seeking medical care.

Signature of patient *Date*

STATEMENT OF PATIENT FINANICAL RESPONSIBILITY

- Most podiatric services are not covered by the R.A.M.Q., but may be reimbursed by private health insurance. You are responsible for verifying your coverage.
- Patients with private health insurance should remember that professional services are rendered and billed to the patient, not the insurance company. Your insurance is a personal contract between you and your insurance company. Payment is due in full on the date of service. We accept cash, check, Visa, MasterCard, and American Express.
- Surgical procedures must be paid for in advance. The payment will be due on the date the procedure is performed.

Signature of patient *Date*

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