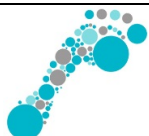


PATIENT REGISTRATION FORM

				Today's date	
PATIENT INFORMATION					
Surname of patient		Given name(s) of patient		Date of birth	
Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height	Weight		Shoe size
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? <input type="checkbox"/> Friend or family member <input type="checkbox"/> Doctor or other medical professional <input type="checkbox"/> Internet or our website <input type="checkbox"/> Other (please specify):				Name of person who referred you	
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... <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Frequently walking around <input type="checkbox"/> Wearing steel-toed shoes			
What is the reason for your visit to a podiatrist today?					
If injury, is it work-related? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you tried any treatments already?			

PERSONAL HEALTH HISTORY	
Please list any current and past medical conditions:	
Any major surgeries or hospitalizations? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please explain:



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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many cigarettes or packs per day?
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Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many drinks per day/week?
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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 FINANCIAL 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

