SIMCOE FOOT CARE & CUSTOM ORTHOTIC CENTRE

MEDICAL CONSENT UPDATE

Name: _____

Address: _____

Preferred Contact Method: (Please circle one) *Home Phone* *Cell Phone* *Work Phone* *Email*

Phone #: Home #: _____ Cell #: _____

Work #: _____ Email: _____

Date of Birth: _____ Family Physician: _____

ALLERGIES: No known allergies: □

List Allergies:_____

Do you take a blood thinner? _____ If yes, name of blood thinner? _____

MEDICATIONS: _____

_____

_____

MEDICAL CONDITIONS: _____

_____

PATIENT'S CONSENT: (Please read & initial your consent on each line below)

___ I understand this Clinic has several Chiropodists all focused on my treatment plan and I consent to seeing the Chiropodist available at my appointment time which may differ from the original Chiropodist booked.

___ I allow photographs of treatment areas to be taken for the purposes of monitoring and education.

___ I consent/allow the Chiropodist to contact and/or send my Physician or health care professional any pertinent information required regarding my foot exam and/or treatment plan or medical information.

___ I understand that I am financially responsible for all charges whether covered by my health insurance plan or not. I understand that service fees are payable at the time service is provided.

Patient's Signature): _____Date: _____

Guardian Signature: _____Relationship:_____
Print Name of Guardian: _____

We promise to treat your personal information with respect. Our privacy protocols comply with privacy legislation, the standards of the College of Chiropodists of Ontario and the law. Be assured that everyone in our office is committed to ensuring that you receive the best quality foot care.