NORTH HILL FOOT & ANKLE CLINIC

PATIENT INFORMATION

NAME: (LAST)_____ (FIRST)_____ (M.I.)_____

ADDRESS: _____ **CITY:** _____

PROVINCE: _____ **POSTAL CODE:** _____ **PHONE:** ( )_____-_____H

BIRTHDAY: (D)_____ (M)_____ (Y)_____ **AGE:** _____ ( )_____-_____C

AB HEALTH #: _____ **SEX:** M F ( )_____-_____O

OCCUPATION: _____ **EMAIL:** _____

REFERRED BY: ( )Family Doctor ( )Yellow Pages ( )Family ( )Friend ( )Internet ( )Physio ( )Nurse ( )Health Care Professional ( )Window Signage ( )Facebook ( )Other Ads ( )Other

EMERGENCY CONTACT: _____ PHONE #: _____

FAMILY DOCTOR: _____ PHONE #: _____

FOOT/ANKLE CONCERN: (including duration)

_____

_____

MEDICATIONS: (please provide list or pharmacy information if list is extensive)

_____

_____

ALLERGIES:

_____

_____

PERTINENT DIAGNOSTIC IMAGING / BLOODWORK: (include locations)

_____

_____

PREVIOUS SURGERIES: (please note any heart valve or joint replacements)

_____

_____

CONSENT FOR TREAMENT

To the best of my knowledge, the above information is correct. I hereby give my permission to Dr. Crosby of the North Hill Foot & Ankle Clinic to administer treatment and perform such procedures as deemed necessary in the diagnosis and/or treatment of my foot/ankle condition as agreed upon by myself. I understand that podiatry is partially covered by Alberta Health Care. I agree to be financially responsible for all charges as related to my care.

- I understand that I am responsible for third party billing arrangements required on my behalf. North Hill Foot & Ankle Clinic will provide appropriate receipts or documents required for such claims.
- I understand that Non Insured First Nations Health Benefits and Department of Veteran Affairs claims are exceptions to the rule and will be billed directly by North Hill Foot & Ankle Clinic providing approval has been established **prior** to my appointment.
- I understand that if this is a WCB related injury, North Hill Foot & Ankle Clinic will assist me with the diagnosis and/or treatment of my foot/ankle concern. North Hill Foot & Ankle Clinic **will not** however, intercede on my behalf with the Workers' Compensation Board, and I will remain financially responsible for my care.

I will be responsible for my appointment time and will provide North Hill Foot & Ankle Clinic with at least 24 hour notice of cancellation. I understand that should I NOT provide the appropriate notice, I will be charged a missed appointment fee.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY AND RELATIONSHIP TO THE PATIENT:

_____

DATE: _____