# 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 (  )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**:

_____

**OR**

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

_____

**DATE:** _____