**PATIENT INTAKE FORM (Update) CINDY CHOW CHIROPODY PROFESSIONAL CORP.**

***Please Print Clearly.***  *All information is kept confidential. Refer to our privacy policy.* **Date:**

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| **Last name**姓:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First & Middle name**名字:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Birthdate**:(DD)\_­\_\_\_ (MM)\_­\_\_\_ (YYYY)\_\_\_\_\_\_\_出生日期**Age**:\_\_\_ **Gender**:❑M ❑F ❑Non-binary **Nickname**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unit #:\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code:\_\_\_\_\_\_\_\_\_\_\_  **Phone: Cell(\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_ Home(\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_ Work(\_\_\_) \_\_\_\_-\_\_\_\_\_\_\_**  ;**E-mail**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Language**:❑English ❑Cantonese ❑Mandarin ❑other:\_\_\_\_\_\_\_\_\_  **Emergency Contact Person:** Phone ( ) - Relation to you: | | |
| **My purpose / reason(s) for coming is**:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **I found you by**:❑Web search ❑Clinic/Person:\_\_\_\_\_\_\_\_\_\_  **Occupation**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑Student ❑Retired  **Shoe size**: \_\_\_ to \_\_\_ **Average hours on my feet per day:** \_\_\_\_\_\_\_\_\_  **Orthotics (shoe inserts):** Yes / No  Year made: \_\_\_\_ I wear them: Yes / No | **FOOTWEAR**  *At-home:* ❑Barefoot ❑Socks ❑Slippers ❑Sandals  ❑Clogs ❑Shoes  *Outdoors*: ❑Sport ❑Casual (❑elastic laces ❑slip-on) ❑Safety  ❑Flats ❑Heels ❑Sandals ❑Flip-flops ❑ \_\_\_\_\_\_\_\_\_\_\_  **EXERCISE** ❑Walking\_\_\_\_ ❑Running\_\_\_\_ ❑Dance\_\_\_\_\_ ❑Racquet Sport\_\_\_\_\_ ❑Gymnastics\_\_\_\_ ❑Weight-Lift\_\_\_\_ ❑Tai-Chi\_\_\_ ❑Basketball\_\_\_ ❑Soccer\_\_\_\_ ❑other\_\_\_\_\_\_\_ | |
| **MEDICAL CONDITIONS / ILLNESSES** Please circle all that apply.  **醫療疾病 / 狀況** 請圈所有適合。**資料绝對保密**。 | | |
| Head/Eyes/Ears/Nose/Throat  Brain Injury 腦損傷  Epilepsy 癲癇  Dementia 失智症  Alzheimer’s Disease 阿爾茨海默氏病  Parkinson’s Disease 帕金森氏病  Cataract 白內障  Glaucoma 青光眼  Hearing Loss 聽力損失  Respiratory  Shortness of Breath 氣促  Asthma 哮喘  Lung Disease 肺部疾病  Cardio Vascular  High Cholesterol 高膽固醇  Low Blood Pressure 低血壓  High Blood Pressure 高血壓  Poor Circulation **血液循環不良**  Heart disease 心臟病  Heart Attack 心臟病發  Stroke 中風  Bleeding Disorders 出血性疾病  Anemia 貧血  GI & GU  Stomach issue 胃病  Intestinal Problem 腸道問題  Endocrinology  Diabetes   borderline/type 1/type 2   **糖尿病**: 臨界/類型1/類型2  Hypothyroidism 甲狀腺功能減退症  Hepatitis A,B,C 肝炎  Liver Disease 肝病  Musculo Skeletal  Balancing Problems 平衡問題  Arthritis 關節炎  Gout 痛風  Osteoporosis 骨質疏鬆  Back Pain / Problems 背部疼痛  Shoulder Pain 肩部疼痛  Neck Pain 頸部疼痛  Neurological  Fibromyalgia 纖維肌痛  Foot Numbness 足麻痺  No Feeling in the Feet 足沒感覺  Paralysis 癱瘓  Other  Compulsive Obsessive Disorder 強迫症  Depression 抑鬱症  Cancer 癌症  Smoker 抽煙者  Skin Problem 皮膚病  Autoimmune Disease自身免疫性疾病  Lupus 狼瘡  Psoriasis | | |
| **Other Illness/Medical Problem(s)** 其他醫療問題:  Past Surgeries 曾**有以下手術**: | | |
| **ALLERGIES 過敏:** ❑None沒有 ❑Penicillin 盤尼西林 ❑Aspirin 亞氏匹靈 ❑Codeine可待因 ❑Iodine 錪酒  ❑Adhesive Tape膠布 ❑Sulfa Drugs 琉堭劑 ❑Local Anesthetic局部麻醉 ❑Other其他: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **MEDICATIONS 當前藥物:** ❑ None 沒有 ❑ See separate sheet of my list of medications 請閱覽附上紙章  ❑ I will provide a list next visit 我會下一次提供藥物.1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_  3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **General Practitioner/Family Doctor**: Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_  Address or nearest intersection (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I give permission to communicate with my doctor: Yes/No Date of last physical exam: | |
| **If you have INSURANCE, may we have the Insurance Company name?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Not required below if you are not seeking an estimate letter from us:**  Policy/Plan/Group#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Certificate/Member ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of Plan Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:(DD)\_\_\_(MM)\_\_\_(YYYY)\_\_\_\_\_  Relationship to plan holder: ❑Self ❑Spouse ❑Child/Dependent Case worker if any: | |

I consent to receive the initial assessment by the chiropodist Ms. Cindy Chow. I will verbally inform her of my wish for any treatment. AGREEMENT shown by a CHECKMARK IN THIS BOX: ❑ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT CONTRACT with FEES LIST**

**of Cindy Chow Chiropody Professional Corporation (Village Foot & Orthotic Clinic)**

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| Cindy Chow, DCh., BSc. ***Registered Chiropodist***  Alicia Chow, B.A. *Receptionist/Assistant* | Phone: (905) 943-7575 |

CLINIC POLICIES:

* Payment is due when services are rendered. **Not covered under OHIP.**
* The patient will be charged for Missed Appointment visits when 24-hour cancellation notice is not given (to **call** the clinic for cancellations). See below for details.
* The patient is responsible for any deductibles and co-insurance fees. Please be informed of your own private health insurance plan(s) or 3rd party payers (such as ODSP, Toronto Social Services, DVA, WSIB).

**FEE SCHEDULE** of **SERVICES / PRODUCTS** - SUBJECT TO CHANGE WITHOUT NOTICE **PRICE $**

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| INITIAL VISIT: ***45 minutes maximum time allotted for a regular initial visit*. *Overtime will be charged at $5.00 for every 5 minutes past 45 minutes*.** ……..…….  (**SENIORS** DISCOUNT for age 65 + years .................…..…………………………..…)  RETURN VISIT: ***30 minutes maximum time allotted for a regular return visit. Overtime will be charged at $5.00 for every 5 minutes past 30 minutes***.……………  (**SENIORS** DISCOUNT for age 65 + years........…..……………………………………)  CUSTOM-MADE ORTHOTICS (INSERTS)………………………………………………….  (**SENIORS** DISCOUNT for age 65 + years .................….……………….……...……..)  *The official receipt for custom orthotics is issued AFTER the orthotics are made, and NOT when they are ordered. This is because all insurance companies expect custom orthotics to be finished before you may make a claim. Even if you pay the total fee on the day of ordering, we will not issue you the receipt that day.*  PODIATRIC BIOMECHANICAL ASSESSMENT & GAIT ANALYSIS …………………….  *No insurance report and No prescription will be given if this above biomechanical assessment is not going to be ordered at this clinic of ours. Only a one-page copy of the file’s “Assessment Note” is available upon request.*  ORTHOPEDIC STOCK (and STOCK-MODIFIED) FOOTWEAR………………………….  *Patient needs to pay at least half of the total as a deposit on the day items are ordered.*  COMPRESSION STOCKINGS………………………………………………………………  MISSED APPOINTMENT IF 24 HOUR NOTICE IS NOT GIVEN**. A Missed Appointment is one when the patient does not come at the appointed time and misses it by 15 minutes or more.** **Exempt** are medical emergencies & extreme weather conditions. **Not exempt** from this charge: you forgot the appointment, change of work schedule, another appointment caused you to be late. As a courtesy, **we may call** to remind you of your appointment. **We make no guarantees we will** remind you of your appointment, so you must remind yourself | | | .………...$**85** AND UP+  .………($**60** AND UP+)  ……..…**$55** AND UP+  ………(**$45** AND UP+)  ……….**$490 to $590**  ………….(**$400** and up)  …………….….…$150  ………….$350 and up  ....……….$160 and up    ………..……………$20 | |
| * I understand and agree to the aforementioned policy and terms. * Failure on my part to comply shall authorize the clinic CINDY CHOW CHIROPODY PROFESSIONAL CORPORATION to charge me the outstanding fees upon my next visit. * I agree to pay for services and / or products rendered which are not covered by my insurance company. * I understand prices are subject to change in the future. | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature (or parent or guardian of patient)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_  Name (PLEASE PRINT) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | | | |