Tel: 533-2508
Email: info@atlantic-podiatry.com
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WELCOME TO ATLANTIC PODIATRY

Patient Information and Credit card Authorisation Form

Personal Details

Full name of patient: ____

Mailing Address: ____

Physical address, if different: ____

Phone number, Cell: ____________________ Home: ____________________ Work: ____________________

Email Address: ____

Date of birth: Day________ Month __________ Year __________ Sex: M F Marital Status: M S W D

Employer: ____

Insurance Details

Provider: ______________________ Group number: ______________________

Certificate: ______________________ Effective Date: ______________________

Primary insured, if not patient: ____

Relationship to primary insured: Self Spouse Child

Employer of primary insured: ____

Address of primary insured: ____

Phone number of primary insured: ____

Emergency Contact

Name: ______________________________ Relationship to client: ____________________

Phone number(s): ____

General Practitioner Details

Name of Practitioner: ______________________ Clinic Name: ______________________

Do you consent that we communicate with your GP about your condition if necessary: Yes / No

Are you under other physical care? Yes / No

If yes, name and profession of practitioner: ____

Reason for your visit

What is the main reason for your visit: ____

When did this begin: ____

How did this begin: ____

Has this occurred before: Yes / No When: _______________ Is it: Getting worse / Staying the same / Improving

How did you become aware of our clinic: ____

Medical & Foot Health History

Please tick (✔) next to any condition you presently have. Please cross (X) next to any condition you have previously had

Ankle Injury	Circulatory Problems	Heel Pain	Knee Pain	Rheumatoid Arthritis
Ankle Pain	Corns/Callous	High blood pressure	Liver Disease	Skin Conditions
Arch Pain	Cramps in legs	High Cholesterol	Neuropathy	Swelling in the feet
Arthritis	Diabetes	Hip Pain	Numbness in the feet	Tired/Aching Feet
Bleeding Disorder	Flat feet	H.I.V/ AIDS	Plantar Fasciitis	Leg/ Foot Ulcers
Blood Clot	Fungal Nail Infection	Itching/Rash on feet	Pregnancy	Varicose Veins
Bunions	Gout	Kidney Disease	Sciatica	Walking Problems
Cancer	Healing Issues	In-grown Toenail	Shin Splints	Warts

Other (Please Specify): ____

Do you have any allergies or have you had any reactions to adhesive tape, latex. Iodine, local aesthetic, or antibiotics?

Details: ____

Have you ever been to a Podiatrist? Yes / No

If yes, when/where was your last visit: ____

AUTHORISATION TO RELEASE INFORMATION AND PAY INSURANCE BENEFITS.

I hereby authorize the practice to render podiatric medical services to me / my child / my elderly relative and to release any information regarding diagnosis and treatment of myself (my child or elderly relative) to my Insurance company regarding my claim. I also authorise payment directly to Atlantic Podiatry of benefits and I understand that I am responsible for any amount not covered by my insurance Company.

____

Signature of Patient/Guardian

Patient/Guardians' Name: ______________________________ **Date:** ____________________

(Please Print)