STRATHCONA
FOOT & ANKLE CLINIC

NEW PATIENT FORM

PLEASE BRING WITH YOU ON YOUR INITIAL VISIT

PERSONAL INFORMATION

First Name: _____ Last Name: _____ Alberta Health Care: _____

Address: _____ Date of Birth: _____
STREET CITY PROVINCE POSTAL MM / DD / YYYY

Home Phone: _____ Work Phone: _____ Email Address: _____

Occupation: _____ Shoe Size: _____ Weight: _____

Family Physician: _____ Emergency Contact: _____
NAME RELATIONSHIP PHONE

MEDICAL HISTORY

Allergies and Sensitivities: _____
***Example*:** *Drug, Adhesive Tape, Latex, etc.*

Current Medical Conditions: _____

Current Medications: _____

OTHER INFORMATION

Have you received treatment from a podiatrist in the past? _____

_____

The Reason For Your Visit: _____ How Did You Hear About Us? _____

I certify that the above information is true and correct to the best of my knowledge. I give my permission to administer and perform such procedure as deemed necessary in the diagnosis and/or treatment of my condition. I certify that I have insurance with Alberta Health and authorize the doctor to release information to Alberta Health to secure payment of benefits. I also realize that certain visits will incur a co-payment.

Name: _____ **Signature**: _____ **Date**: _____
MM / DD / YYYY