PRICE PRESTON
PODIATRY

Dr. Natalie Price Preston & Dr. Ryan Hartlen

Name:___________________________________ **Date of birth**: (M/D/Y)______________________

Address:_________________________________ **City**:_________________ **Postal Code**:______________

Phone: (H) _____________________ (C) _______________________ (W)_______________________

Emergency Contact:_______________________ **Relationship**:_______________ **Phone** :_____________

Health Insurance: Blue Cross:_____ Greenshield:______ Great West Life:_____ Desjardins:______
Sunlife:_____ Manulife:_____ DVA: K#__________ Other Plan:___________________

Height:________ **Weight**:_______lbs **Shoe Size**:________ **Occupation**:__________________________

Family Doctor:______________________________ **Referred by**:__________________________________

How did you hear about us?

☐Internet/ Social media ☐Doctor ☐Friend/Family: ________________ ☐Other:__________________

Why are you here today? Explain your current problem: _____________________________________

____

Allergies:____

Medications (If you have a list, we can make a copy): ____

____

Surgical Procedures (Orthopaedic):____

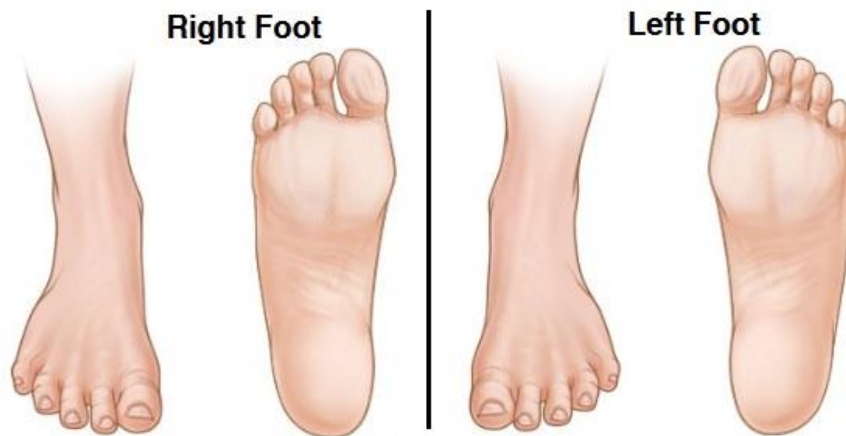
Do you have or have you been treated for any of the following?

- Anemia (low B12)
- Anxiety
- Asthma
- Cancer
- Depression
- Diabetes
  Type 1 or Type 2
- Eczema
- Emphysema
- Epilepsy
- Fibromyalgia
- Gout
- Heart attack
- Hepatitis A/B/C
- High blood pressure
- Low Blood pressure
- High cholesterol
- Kidney disease
- Liver disease
- Lupus
- Multiple Sclerosis
- Muscular Dystrophy
- Osteoarthritis
- Osteoporosis
- Polio
- Psoriasis
- Psoriatic Arthritis
- Rheumatoid Arthritis
- Stroke
- Thyroid Disease
- Varicose Veins
- Other:____________
  ____
  ____
  ____
  ____
  ____
  ____

Do you use custom orthotics (shoe inserts)? ☐No ☐Yes From where?_____________________When?___________

What type of shoes do you wear most? Work:___________________________ Leisure: ___________________________

On these pictures, mark the area of your foot where the problem is.



Please indicate consent by placing your INITIALS in the boxes below

Cost of our services

☐ I understand that I am financially responsible for all the fees and that these are payable at the time the service is provided whether covered by my health insurance plan or not. Receipts will be issues to claim reimbursement from health plans or for income tax purposes. An appointment fee will be applied for appointments cancelled with less than 24 hours notice and for missed appointments.

Consent for obtaining, collecting and releasing personal information

☐ I authorize Price Preston Podiatry to request/release medical information regarding my diagnoses, treatment and prognosis from/to persons relevant to my care (physicians/health care providers/ funding sources/ etc.)

☐ I understand that the personal information collected/released by Price Preston Podiatry (in paper, electronic, or photograph form) will be treated with respect and comply with Privacy Regulations, the Standards of the New Brunswick Podiatry Association, and the Law. I understand that I may view Price Preston Podiatry's Clinic Privacy Policy on request.

☐ I consent to photographs to be taken of the treatment areas for the purposes of monitoring.

We would like to use email communication for <u>appointment reminders</u> for office efficiency. No spam will be sent.

☐ Please indicate your consent and provide your email address: ____

Informed consent to podiatry treatment

I hereby request and consent to the performance of podiatry treatment and other podiatry procedures. I further understand and am informed that, as in all health care, in the practice of podiatry there are some risks to treatment, including but not limited to pain, swelling, and infection. I do not expect the podiatrist to be able to anticipate and explain all risks and complications and I wish to rely on the podiatrist to exercise good judgement during the course of the procedure which the podiatrists feel at the time, based on the facts known, and is in my best interest.

I have read the above consent. By signing below, I agree to the procedures that the Podiatrist deems necessary in accordance with my condition. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment. If at any time during the course of treatment, I wish to withdraw my consent, I may do so in writing.

Signature: ____________________________________ Date: ______________________________________