Todd Hrycyshyn, D.Ch., B.Sc., - Registered Chiropodist
3-1420 Bayly St 905-420-7231

Patient Information Form

Welcome to the Chiropractic Centre on Bayly St - Chiropody services. We're dedicated to providing exceptional footcare for people of all ages. Please help us get to know you better by providing the following information:

First Name: _____ Last Name: _____

Address: _____ City: _____ Postal Code: _____

Phone: (Home) _____ (Cell) _____

Date of Birth: m/ _____ d/ _____ y/ _____ Email: _____

Parent/Guardian Names (if child is under 18) Mother: _____ Father: _____

Emergency Contact: _____ Relationship: _____

Insurance Provider: _____

Your Occupation: _____ Employer: _____

How would you like your appointments confirmed? ❑ Email ❑ Phone

HOW DID YOU HEAR ABOUT THE CLINIC?

❑ Friend/ family/ colleague _____
(please indicate referrer's name so we may thank them)

❑ Internet ❑ Newspaper ❑ Health Care Professional

❑ Yellow Pages ❑ Other _____ (please specify)

PLEASE ANSWER THE FOLLOWING FOOT RELATED QUESTIONS

Your primary complaint involves: ❑ Right foot ❑ Left foot ❑ Other Explain: _____

How long have the symptoms been present? ❑ 0 to 8 weeks ❑ 2 to 6 months
❑ 6 to 12 months ❑ 1 year +

Have you been treated for any of the following? (Check all that apply)

❑ Flat feet	❑ Corn(s) / callus	❑ Plantar wart(s)	❑ Toenail fungus	❑ Athletes foot
❑ Heel pain	❑ Ingrown toenails	❑ Bunion(s)	❑ Hammer toe(s)	❑ Cracked heels
❑ Arch pain	❑ Ankle injury / pain	❑ Knee / back pain	❑ Ball of foot injury	❑ Neuroma

Have you ever worn custom foot orthotics? ❑ Yes ❑ No

What is your current? **Height** _____'_____" **Weight** _____ lbs / Kg, **Shoe Size:** _____

PATIENT MEDICAL HISTORY

Please list your **current medications**:_____

_____

_____

Diabetes: ❑ Type 1 ❑ Type 2 ❑ Pre-Diabetes Year Diagnosed: _____

Complications: _____

Do you take a blood thinner (Aspirin, Coumadin): ❑ Yes ❑ No

Have you been treated for any of the following? (Please mark all that apply)

❑ Angina / Chest pain	❑ Heart Attack	❑ Psoriasis	❑ High blood pressure
❑ Rheumatoid Arthritis	❑ Kidney disease	❑ Eczema	❑ Congestive Heart Failure
❑ Osteoarthritis	❑ Dementia	❑ Poor circulation	❑ Stroke / CVA
❑ HIV / AIDS	❑ Epilepsy	❑ Liver Disease	❑ Thyroid Disorder (Hypo / Hyper

Other:_____

_____

_____

_____

_____

Allergies (Please list all known): _____

_____

PATIENT CONSENT AND AUTHORIZATION FOR CHIROPODY TREATMENT

I hereby request and consent to the performance of Chiropody treatment and other Chiropody procedures, including various modes of physical therapy by the chiropodist and/or anyone working in this clinic authorized by the Chiropodist.

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

Insurance: Chiropody services and products are covered under most extended health insurance plans. Payment for Chiropody services and or products are expected in full after each visit. Details of your insurance coverage is your responsibility. Please contact your insurance provider with questions regarding your coverage. Co-payments and or deductibles with your insurance provider are your responsibility. You are responsible for any unpaid balance for Chiropody services and or products that are unpaid by your insurance provider.

Assignment of Benefits: If you elect to have your insurance provider assign your benefits to Todd Hrycyshyn D.Ch., you certify that you (or any dependents) have coverage with an insurance provider as presented and assign payment directly to Todd Hrycyshyn D.Ch. for all services rendered and products dispensed. Any unpaid balances with be processed to the pre-authorized method of payment on file.

PATIENT SIGNATURE (Parent / Guardian if under 16) :_____

Date (mm/dd/yyyy): _____