New Patient Form

PATIENT NAME: ______________________________ **ALB HEALTH NO:** ______________________________

Address: ____ Age: ____________
Street City Prov Postal Code

BIRTHDATE: _______________ **Home Ph. No:** ________________ Work Ph. No: ________________

Family Physician: ______________________________

Emergency Contact: ______________________________ Relationship: ____________ Ph. No: ____________

THE REASON FOR YOUR VISIT TODAY:

____

WHAT OTHER CONDITIONS ARE YOU CURRENTLY BEING TREATED FOR: ______________________________

____

CURRENT MEDICATIONS: ____

____

ALLERGIES/DRUG SENSITIVITIES: ____

SURGERIES & APPROXIMATE DATES: ____

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OCCUPATION: ______________________________ (This helps us understand how you use your feet)

SHOE SIZE: __________ **WEIGHT:** ____________

HOW DID YOU HEAR ABOUT STEP AHEAD PODIATRY CLINICS? ______________________________

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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.

______________________________ (Responsible Party Signature) ____________________ Date