MEDICAL HISTORY

PATIENT NAME:_____ **ALB HEALTH NO:** _____ - _____

Address:_____ Age: _____
Street City Prov Postal Code

BIRTHDATE: ____/____/____ **PRIMARY Ph. No:**_____ ALT Ph. No:_____
Year Month Day

EMAIL: _____ **Family Physician:** _____

SEND EMAIL NOTIFICATIONS: *YES OR NO (PLEASE CIRCLE ONE)*

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: _____

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

SHOE SIZE: _____ **WEIGHT:** _____

HOW DID YOU HEAR ABOUT STEP AHEAD PODIATRY CLINICS?_____

PATIENT CANCELLATION POLICY: In order for Step Ahead Podiatry to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointment and arrive in a timely manner. Please note that Step Ahead Podiatry reserves the right to bill you $40 for missed appointments or late cancellations (less than 24 hours). This fee will be your responsibility and will not be billed to your insurance. We realize that on rare occasions emergencies arise and these situations will be addressed with you at that time.

REFUND POLICY: There are no refunds on prescription devices and/or footwear. I have read and understand the above mentioned policies.

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