

# Patient Intake Form

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ASSESSMENT DATE (MM/DD/YY): \_\_\_\_\_

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

## COVID-19

Are you currently experiencing (please check all that apply):

FEVER

NEW COUGH

NEW SHORTNESS OF BREATH

## CONTACT INFORMATION

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_

PROVINCE: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

HOW WOULD YOU LIKE US TO CONFIRM APPOINTMENTS:  PHONE

HOME  WORK  CELL  TEXT  EMAIL

## PERSONAL INFORMATION

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

SHOE SIZE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

NUMBER OF WEIGHT-BEARING HOURS: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

INSURANCE: \_\_\_\_\_

GUARDIAN: \_\_\_\_\_

FAMILY DOCTOR/NP: \_\_\_\_\_

## HOW DID YOU HEAR ABOUT US?

FACEBOOK

FAMILY DOCTOR/NP

FRIEND/FAMILY REFERRAL

WEBSITE

ROAD SIGN

STOREFRONT

GOOGLE

PREVIOUS BIOPED CLIENT

OTHER (PLEASE SPECIFY): \_\_\_\_\_

## REASON FOR YOUR VISIT

In detail, please describe the area of complaint, duration of symptoms, aggravating factors:

On a scale of 1-10 please indicate the degree of pain you're experiencing (0 = no pain at all, 10 = the worst pain you have ever experienced)

0      1      2      3      4      5      6      7      8      9      10

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Patient Privacy & Consent to Assessment

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## YOUR PRIVACY

As your privacy is an important part of our clinic protocol, our staff are aware and trained in the appropriate uses and protection of your information in order to ensure confidentiality.

Our clinic collects, uses and discloses personal information for the purpose of providing treatment and services to our patients. BioPed has a corporate commitment, and our BioPed Clinicians (which includes our Podiatrists, Chiropodists, Foot Care Nurses and Physiotherapists) and clinic staff have a professional obligation to keep all personal information, in our possession, confidential and secure.

Information that we may collect includes your name, address, email address, phone number, birth date, height, weight, medical conditions and history, allergies, health insurance and benefit claim information.

We will use and disclose this information only for the following purposes:

- To ensure the accuracy of information on file and to be able to contact you
- To comply with professional, legal and regulatory requirements or as otherwise required by law
- To provide health plan insurers information in order to process your claims and benefits
- To confer with your health care provider or inform them about your treatment plan
- To inform you of additional services offered by BioPed which may be beneficial to you

BioPed will never disclose patient information, except in those circumstances listed above. If you do not wish us to use and disclose this information for the purposes described above, please advise our staff who will make a notation in your file. If this decision on your part limits the clinician from providing you with appropriate treatment, you will be advised accordingly.

## PATIENT CONSENT

I have read and understand the contents of this form. I consent to the BioPed Clinician performing an assessment. I further understand that the BioPed Clinician will review treatment recommendations and options with me following the assessment and during future appointments at BioPed Footcare. By signing this consent form, you are confirming that:

- All information in this form is correct to your best knowledge.
- You give your informed consent to the collection, use and disclosure of information for the purposes identified in this form.

## EMAIL CONSENT

- I provide consent to receive BioPed emails, including offers and promotions, newsletters and company updates. I understand that I can withdraw this consent at any time.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
OR LEGAL GUARDIAN

PATIENT NAME (PLEASE PRINT): \_\_\_\_\_  
OR LEGAL GUARDIAN

