NEW PATIENT FORM

First Name:____________________ Last Name:____________________________

BC Health #:_________________________ Date of Birth:_____________________

Address:_____________________________City:_____________ Postal:________

Home Ph:________________________ Work Ph:___________________________

Cel Ph: ____________________ Email Address:____________________________

Occupation:__________________ Employer:___________________ Gender: M F

How did you hear about our practice? (Please circle): Google/Internet Family/Friends

Doctor/Referral (who?) ___________ Insurance Other _____________

Have you been to see a podiatrist before? Y N

If yes, which podiatrist was treating you?_______________________ How long ago?___

Name of your family Doctor____

Do you have any medical/ drug allergies? Y N If yes, please list____________________

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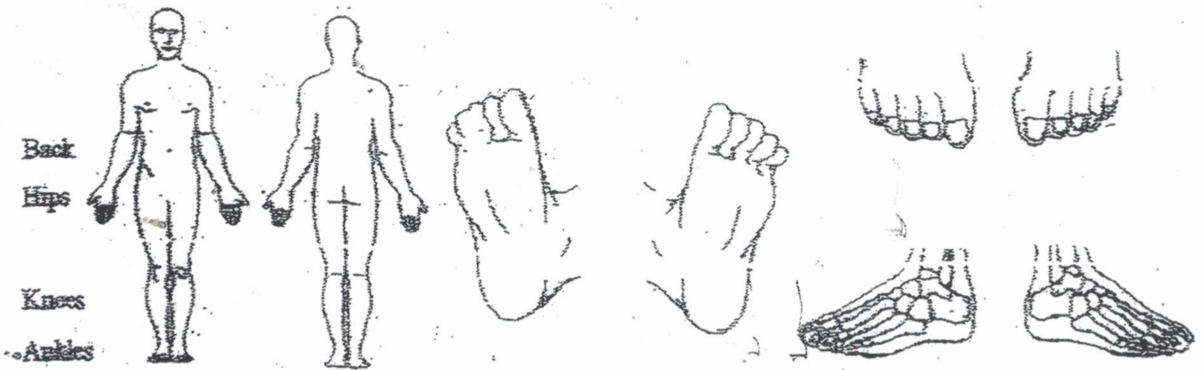
Do you have any of the following conditions (please circle all that apply):

Heart Disease, High Blood Pressure, Poor Circulation, Diabetes, or Arthritis

Please circle the areas where you are experiencing pain or discomfort:



Please describe in your own words your present foot problems (i.e. reason for your visit)___

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How long have you experienced this problem?_________________________________

Please list any other medical conditions you have:____________________________

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Please list any medications you are presently taking:__________________________

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Is there a possibility you may be pregnant? Y N Are you nursing? Y N

Signature:_______________________________________Date:_________________