PATIENT INFORMATION AND PROGRESS NOTES

PATIENT NAME_________________________________DATE OF BIRTH m___d___y___

ADDRESS_______________________________________PHONE home_______________

____PHONE work_______________

OCCUPATION___________________________________

HEIGHT ft._______ in.______ WEIGHT lbs._______ SHOE SIZE u.s._______________

FAMILY DOCTOR______________________________OHIP#______________________

HEALTH PROBLEMS
please list any and all conditions not just foot related include allergies etc.

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MEDICATIONS____

I understand that Chiropody services and products are NOT covered by OHIP and I am responsible for paying these fees at the time of service.

Signature_________________________________date______________________________