



**Living Well Health Centre**

**FOOT CARE  
PATIENT INTAKE FORM**

Assessment Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Gender:  Female  Male  Other Date of Birth: (D/M/Y): \_\_\_\_\_

Street: \_\_\_\_\_ Apartment/Unit #: \_\_\_\_\_

City/Town: \_\_\_\_\_ Province/State: \_\_\_\_\_

Country: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone (H): \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ Email: \_\_\_\_\_

Phone (M): \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Phone (W): \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Preferred Contact Method:  Email  Phone

Contact #:  Home  Cell  Work

Contact Time:  Day  Evening

Occupation/Type of Work: \_\_\_\_\_

# of Weight Bearing Hours: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance: \_\_\_\_\_

Guardian: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

- Facebook  BioPed Website  Google Search  Road Sign
- Store Front  Family Physician  Friend Referral  Family Referral
- Previous BioPed Client



## 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. Living Well has a corporate commitment, and our Clinicians 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, gender, 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 and offer you additional services offered by BioPed which may be beneficial to you

**We will never disclose patient information, except in those circumstances listed above.**

## 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 have agreed that you have given 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 Living Well emails, including offers and promotions, newsletters and company updates. I understand that I can withdraw this consent at any time.

**Patient Signature:**  
(or Legal Guardian)

\_\_\_\_\_

**Date:**

\_\_\_\_\_

**Patient Name (Please Print):**  
(or Legal Guardian)

\_\_\_\_\_