FAMILY FOOT CARE CENTRE

ROBERT CHELIN, D.P.M.
STEPHEN PARKER, D.Ch.

FOR PATIENT PROTECTION, ALL INSTRUMENTS ARE COMPLETELY STERILIZED BEFORE EACH TREATMENT ACCORDING TO REGULATIONS.

We are pleased you have confided in us for your foot care. The staff wishes to welcome you to our office. We take pride in our professional capabilities and will attempt to accommodate you in every way possible. We accept new patients without Doctor referral. Adult foot problems begin in childhood. Please have your children's, grandchildren's feet examined!

Please answer the following questions **fully** to help us become better acquainted. If you need assistance do not hesitate to ask the receptionist.

Name _____ Date _____

Parent or Guardian's name if patient is under age 18 _____

Address _____ Apt. # _____

City/Town _____ Postal Code |_|_|_| - |_|_|_|

Phone Number (Home) ( ) _____ (Work) ( ) _____ Ext. _____

Health Card Number |_|_|_|_|_|_|_|_|_|_| |_| Version Code

Date of Birth DAY |_|_| MONTH |_|_| YEAR |_|_|

Shoe Size _____ Weight _____ Age _____

Occupation _____

Employer _____

Are you or your spouse covered under any additional type of medical insurance that covers prescriptions, eyeglasses or dental eg: Great West Life, Blue Cross, Aetna, etc.

☐ Yes ☐ No _____

How did you hear about our office, or who referred you? _____

Name of person who referred you _____

Are you allergic to medications or materials? ☐ Yes ☐ No

If yes specify _____

Is there a personal or family history of diabetes? ☐ No ☐ Self ☐ Mother ☐ Father

If self: ☐ Pills ☐ Insulin Injections

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