Kiran Dave. D.Ch.
Chiropodist / Foot Specialist

The Education and Treatment Of Foot and Foot Related Functions

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Date: ________________________

Patient Name: ___________________________ Date of Birth ___________________________

Address ____

City/Town _____________________________ Province ______________________________

Postal Code____________________ Email Address. ________________________________

Home Phone No. ________________________Cell No. ________________________________

Business No. __________________________

Referred By ______________________________ Examined By: _________________________

Family Doctor ____

Family Doctor Address____

Family Doctor Phone: ____________________________

Do you have any of the following? Comments

		Comments
Eye, Ear, Nose or Throat problems	Yes/No	__________________________
Respiratory Problems	Yes/No	__________________________
Heart Problems	Yes/No	__________________________
Diabetes in the family	Yes/No	__________________________
Kidney/Liver problems	Yes/No	__________________________
Infectious diseases	Yes/No	__________________________
Circulatory diseases	Yes/No	__________________________
Bleeding diseases	Yes/No	__________________________
Arthritis, osteoporosis, back, knee or leg pains	Yes/No	__________________________
Skin diseases	Yes/No	__________________________
Nerve disease	Yes/No	__________________________

Over →

3105 Glen Erin Drive Suite 5, Mississauga, Ontario, L5L-1J3
Tel: (905) 828-2014
Fax: (905) 828-8822

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Any other diseases	Yes/No	____________________
Do you take medication (***if yes, please list***)	Yes/No	____________________
Do you have allergies	Yes/No	____________________
Have you had any operations	Yes/No	____________________
Have you broken any bones	Yes/No	____________________

Any other information I should be aware of? ________________________________

____

____

What is your chief complaint ________________________________

____

We will gladly assist you in understanding your insurance coverage, but you agree that you are responsible for your account.

I agree to Erin Mills Optimum Health collecting and using personal information about me as set out in their Privacy Policy, which I have an opportunity to review at any time.

Please note that a cancellation service charge will apply if less than 48 hours notice has been given.

Fee:

Initial Assessment:	$80.00
Subsequent Visit:	$55.00
X-Rays (if necessary):	$100.00
Custom Orthotics (if necessary):	$550.00

I have read the above and consent to care at Erin Mills Optimum Health.

____________	____________________	____________________
Date	**Patient Name**	**Patient Signature**

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