NEW PATIENT INFORMATION FORM

Michael Mesic & Associates, Doctors of Podiatric Medicine

Please fill out **both pages about the patient** to the best of your ability and **sign**. Ask for assistance if required.

Date Today (m/d/yr):____/____/______ Date of Birth (m/d/yr):____/____/_______ Age:_____ Sex: M/ F/ O

Name (*Patients*): **Last** ______________________ **First** ___________________ Middle _____________

Address: _____________________________________ City:______________________ Postal Code: ______________

Home Phone #:_____-_____-________ Cell Phone #: _____-_____-________ Work Phone #:_____-_____-_____

Your Email (for reminders):____________________________@_______________________

Emergency Contact Person:________________________ Relation:_________________ Phone #: _____-_____-_____

Family Doctor:_____________________________ Previous foot care provider(s):___________________________

Referred by: ☐doctor ☐yellow pages ☐website ☐newspaper ☐Google ☐friend:_______________☐other:___________

Have you ever had orthotics (custom shoe inserts)? ☐ Yes ☐ No Age of Orthotics?_________ Made by:________________

Employer:_______________________________________ Occupation:____________________________________

Insurance Company:____________________________ Policy:____

Height:________ Weight:_______ Shoe Size:_____ **If female are you pregnant: ☐Yes ☐No Breastfeeding: ☐Yes ☐No**

CURRENT FOOT PROBLEM:

Please **describe your MAIN foot problem** including location, length of time, any injuries, previous treatments, results, etc

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ILLNESSES or DISEASES:

Have you or do you currently have any of the following:

☐Diabetes	☐Heart Disease	☐Heart Attack	☐High Blood Pressure / Hypertension
☐Osteoarthritis/DJD	☐Rheumatoid Arthritis	☐Gout	☐Other Arthritis ________________________
☐ Heart Murmur	☐Arrhythmia	☐Stroke	☐Heart Valve Prolapse / Replacement
☐Angina	☐Headaches	☐Vision Problems	☐Artificial joint / hip or knee replacement
☐Asthma	☐Lupus	☐Lung Disease	☐Emphysema or COPD
☐Anemia	☐ AIDS/HIV	☐Bleeding Disorders	☐Foot or Leg Wound / Ulcer
☐Night Cramps	☐Varicose/Spider Veins	☐Poor Circulation	☐Calf pain when walking a certain distance
☐Blood Clots/DVT	☐Stomach Ulcers	☐GI/Rectal Bleeding	☐Irritable Bowel Syndrome / Colitis /Crohns
☐Hernia	☐Acid Reflux	☐Epilepsy	☐Thyroid Disease
☐Kidney Problems	☐Fibromyalgia	☐Prostate enlarged	☐Parkinson's Disease
☐Skin Conditions	☐Liver Disease	☐Hepatitis	☐Cancer History/ Type____________________
☐Depression	☐Muscle Disease	☐Pancreatitis	☐Psychiatric Conditions__________________
☐Anxiety	☐Alcohol Dependence	☐Raynauds Disease	☐Hearing Problems / deafness
☐Dementia/Alzheimer's	☐Drug Dependence	☐Autism	☐Osteoporosis / Osteopenia (thin bones)

Please list any other medical conditions not listed above that you have been diagnosed with by a physician:

____

____

(**Please complete 2nd page**) →

ALLERGIES

(**please check appropriate box** if you have had allergies to any of these drugs):

☐ Penicillin ☐ Novocain ☐ Cortisone ☐ Aspirin ☐ Iodine/Shellfish ☐ Tape/Adhesives
☐ Codeine ☐ Latex ☐ Ibuprofen/Advil ☐ Tylenol ☐ Sulfa
☐ Local Anesthetics ☐ Other Antibiotics ________________________
☐ Other Pain Medication ________________________
☐ Non-Steroidal Anti-Inflammatory Medications________________________
☐ Metal Sensitivity: ☐ Nickel ☐ Stainless Steel ☐ Titanium
☐ Other Allergies ________________________

MEDICATIONS:

Please list all drugs you are currently taking – if you have a list please ask secretary to make a copy.
If you do not recall which medications, please state what medical condition you take them for.

Drug	Drug
______	______
______	______
______	______
______	______
______	______
______	______

PREVIOUS SURGERIES, HOSPITALIZATIONS & INJURIES:

____
____
____

FAMILY HISTORY OF ILLNESS (please list any medical conditions that run in the family, including foot problems):

____
____

SOCIAL HISTORY:

Tobacco Use? ☐ No ☐ Yes, how much per day? __________ How many years? ______ Year quit? _________
Alcohol Use? ☐ No ☐ Yes, How many drinks per week? ________________________
Drug Use? ☐ No ☐ Yes, what type? ________________________
Exercise? ☐ No ☐ Yes, Type & Frequency? ________________________

Michael Mesic & Associates, Doctors of Podiatric Medicine are not medical doctors but rather are licensed foot specialists. Michael Mesic was educated in the U.S. as a podiatrist with surgical residency training. He is considered a podiatrist in the U.S., and in all other Canadian provinces, except Ontario where he is a registered chiropodist since he entered after the 1993 cap on podiatrist registrants. None of our services are covered by OHIP. Your initial visit fee and subsequent visit fees do not include fees for additionally performed services and dispensed items. It is the responsibility of the patient to inquire about **additional fees for services / products recommended** and to determine if such items dispensed are covered by any supplemental insurance plan. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.
If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider. The patient is responsible for all fees charged and **payment is expected on the day of your visit** unless your insurance provider lists us as a preferred provider with direct billing set-up. Overdue balances will be subjected to a 2% monthly interest charge. Fees can change without notice. Due to the nature of medicine, no guarantees as to the success of treatment can be made and the patient is responsible for fees charged despite the outcome. Refunds or exchanges will be determined solely by the Canadian Foot Clinic and are not permitted for custom made devices and all other unsellable items. Footwear exchanges or returns are only permitted according to the CFC footwear policy. The patient understands and accepts all risks and complications involved with treatments rendered, advice given and with the use of dispensed or recommended products. The patient permits Michael Mesic, his associates and their staff to communicate with and disclose provided medical and financial information to their physician(s) and insurance companies for the purpose of referral letters, treatment and billing verification, electronic or manual submissions as required. We will not sell your information to third parties unrelated to our practice. **Missed appointments without 48 hours notice will incur a full office visit charge**. The patient agrees to inform our office of any changes in medical history, allergies, medications and if they are nursing, pregnant or trying to become pregnant.

The patient agrees that all information provided on this document is complete, accurate and consents to being treated by the practitioner(s). By signing, the patient agrees to the above listed terms.

Signature:________________________ Date Today (m/d/yr):________________________