PERSONAL and CONFIDENTIAL

Informed Consent to Podiatry Treatment

I hereby request and consent to the performance of podiatry treatment and other podiatry procedures including various modes of physical therapy by the podiatrist and/or anyone working in this clinic authorized by the podiatrist.

I further understand and am informed that, as in all health care, in the practice of podiatry there are some slight risks to treatment, including, but not limited to pain, swelling, infection. I do not expect the podiatrist to be able to anticipate and explain all the risks and complications and I wish to rely on the podiatrist to exercise good judgment during the course or the procedure, based on the facts then known and is in my best interest.

If at any time during the course of treatment I wish to withdraw my consent, I may do so.

For collection and use of personal information as included in this patient file, be assured privacy policies comply with legislation and standards set the Nova Scotia Podiatry Association. Only necessary information is collected and information only shared with your consent.

I CONSENT TO SHARING INFORMATION WITH MY FAMILY DOCTOR, IF REQUIRED:

☐ Yes

☐ No

I also permit the sharing of information with the following: *(only if applicable for your ongoing care)*:

☐ Physiotherapist ☐ Radiology ☐ Care Givers please list:

☐ Family Members, please list:

Name *:* _____ Date: (D/M/Y) _____

Patient Signature: _____

(Parent or Guardian please sign for patients under 18yo)

KEYSTONE PODIATRY

Date: _____

Name: _____ Birth Date (D / M/ Y): _____

Address: _____ City: _____ Postal: _____

Phone: Home # _____ Work # _____ Cell # _____

Email: _____

Emergency Contact Name: _____ Phone _____

Height: _____ Weight _____ Shoe Size _____

How did you hear about us? _____

Family Doctor: _____ Referral: ☐ Yes ☐ No

Allergies: _____

Current Medications: _____

Reason for Today's Visit: _____

Medical History (Check all that Apply):

- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Attack
- ☐ Hepatitis A/B/C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Polio
- ☐ Pregnancy
- ☐ Psoriasis
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Varicose Veins
- ☐ Other: _____

Please list any fractures or replacements: _____