Allied Foot Specialists

Comprehensive Medical & Surgical Management of the Foot

Dr. Alan Boroditsky

Podiatric Medicine, Foot Surgery & Sports Medicine
Clinical Instructor: Faculty of Medicine, Department of Surgery. University of British Columbia

Welcome to the office! Please help us by filling out as much of the information below as possible.

First Name	M.I.	Last Name	Current Age
Birth Date: Month	Day	Year	☐ Male ☐ Female
Address		City	Postal Code
Phone: Home	Work	Cell	Email
Occupation	Care Card #	Private Insurance	
Height	Weight	Shoe Size	Family Doctor
Spouse / Parent / Guardian			Contact Number

Please state the nature of today's visit:

Whom may we thank for referring you to the office?

☐ Family Doctor ☐ Internet / Website ☐ Friend ☐ Yellow Pages ☐ Advertisement ☐ Health Care Professional

Other

Do you have prolonged bleeding after a cut? ☐ No ☐ Yes

Do you smoke? ☐ No ☐ Yes If yes, Quantity For how long?

Do you drink alcohol? ☐ No ☐ Yes If yes, how often? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Socially

Do you have DIABETES? ☐ No ☐ Yes If yes, when were you diagnosed?

Does anyone in the family have diabetes? ☐ No ☐ Yes If yes, who?

Please list your current medications and dosage: ☐ None

Are you allergic to any foods or medications? ☐ No ☐ Yes If yes, please list:

Have you ever been tested for HIV? ☐ No ☐ Yes If yes: ☐ Negative ☐ Positive

Have you ever had Hepatitis? ☐ No ☐ Yes If yes, which type?

Have you had any serious illnesses or operations within the past 5 years? ☐ No ☐ Yes If yes, please list:

Please list any previous foot injuries or foot surgeries:

Do you have, or have you ever had:

☐ Heart Trouble ☐ Eye Problems ☐ High Blood Pressure ☐ Rheumatic Fever ☐ Arthritis ☐ Asthma

☐ Faint Easily ☐ Liver Problems ☐ Stomach Problems ☐ Kidney Problems ☐ Epilepsy

Thank You. Please turn over and read, complete & sign the other side.

Please read and acknowledge the following by signing below:

1. My health insurance coverage under the BC Medical Services Plan is current. If for any reason my MSP coverage is not up to date, then I accept responsibility for payment for services rendered which are an MSP benefit. I understand that MSP does not cover all podiatry services. I understand that payment methods for services are: Cash, Interac/Direct Debit, Visa or Mastercard, and are due at the time services are rendered.

2. ASSIGNMENT OF MEDICAL SERVICES PLAN BENFITS TO OPTED OUT PRACTITIONER
   I authorize the Medical Services Plan to pay Dr. Boroditsky directly for all reimbursements for benefits payable to me under the Medical and Health Care Services Regulation for care provided to me. I make this assignment in full knowledge of the amount that I will be personally responsible for and the amount that is reimbursable by the Medical Services Plan, which will be directed to Dr. Boroditsky to be applied against any outstanding monies I owe for services provided.

3. This form allows the below-named practitioner to receive MSP reimbursement directly for services that are MSP benefits. Your practitioner, by law, must advise you of his full fee and what portion will be reimbursed by MSP. By agreement, your practitioner may not charge you the portion reimbursable by MSP.

Practitioner: Dr. Boroditsky MSP Practitioner & Payment #: 60082

4. I understand that once I make an appointment, both time & space has been reserved for me. If I fail to give a minimum 48 hours notice to cancel or reschedule an appointment or if I don't show-up for a reserved appointment time, I understand that I will be charged a cancellation or no-show fee of $75. This policy allows for mutual consideration for both your time and mine.

Aside from a written reminder slip, I understand that the office will make an attempt to remind me of my appointment time.

I prefer that the office contact me the following way to remind me of such:

☐ Home phone ☐ Cell phone ☐ Email

5. I hereby give my permission for Dr. Boroditsky, or his staff designate, to, if needed, send my medical information to me via email. I understand that email is not secure, but I agree to this consent until further notice:

Please check one: ☐ Yes ☐ No

Any questions regarding my appointments and / or fee payment structure have been addressed. I have read the above statements and fully understand and agree to them.

Name of Patient: _____
Please print

Signature of Patient: _____
Parent or Legal Guardian if under 19

Date Signed: _____

Thank you!