CLINIQUE PODIATRIQUE DE LAVAL

Date: _____ / _____ / _____

PERSONAL INFORMATION

Family Name: _____ First Name: _____

Date of Birth: Y_____ / M_____/ D_____ Age: _____ Gender: F ☐ M ☐ N/A ☐ Weight (lb)____

Primary Phone Number: _____ Cellphone: _____

Email: _____ Shoe Size: _____

Address: _____ City: _____ Postal Code: _____

Occupation: _____

Emergency Contact: _____ Phone Number: _____

Relationship (e.g., spouse, parent, friend): _____

Referral: ☐ Family/Friend: _____ ☐ Passing By ☐ Internet ☐ Heath Professional

MEDICAL HISTORY

Pain: ☐ None ☐ Moderate ☐ Sharp

Reason for Consultation (e.g., foot care, ingrown toenail, wart, pain, orthotics, follow up):

_____

***ALLERGIES**: ☐ Yes ☐ No

*If yes: _____

Please check all medical conditions that apply to you:

☐ Diabetes	☐ Hypercholesterolemia	☐ Arterial Hypertension
☐ Arterial Insufficiency	☐ Venous Insufficiency	☐ Blood Clot
☐ Heart Disease	☐ Liver Disease	☐ Renal Insufficiency
☐ Arthritis	☐ Rheumatoid Arthritis	☐ Gout
☐ Osteoporosis	☐ Heartburn/Acid Reflux	☐ Psoriasis
☐ Eczema	☐ Other: _____	

Are you currently: ☐ Pregnant (if yes, number of months): _____ ☐ Not pregnant ☐ Breastfeeding

*Smoking Status: ☐ Smoker ☐ Non-Smoker

Medication:

Write down your medications below if you did not bring a list from the pharmacy.

☐ I don't take any medication ☐ I brought my medications list

My medication: _____

MEDICAL CONTACTS

PRIMARY CARE PHYSICIAN / SPECIALIST NAME: _____

PHARMACY NAME & PHONE NUMBER: _____

Photo/Video Consent

I authorize my podiatrist to take photos or videos of my condition for medical documentation:

☐ **Yes** ☐ **No**

Notice – Use of AI note-taking tool

Before your appointment, please be informed that we use an artificial intelligence (AI) system to assist with note-taking during consultations. This tool helps us accurately document your visit while allowing the clinician to focus more on you and less on manual typing.

Your privacy and confidentiality remain a top priority. The AI is used solely to improve the quality and efficiency of your care.

By signing this consent, you agree to allow your clinician to use an AI assistant during your consultation.

☐ **YES** ☐ **NO**

Acknowledgment & Signature By signing below, I:

- Accept full responsibility for all charges related to my care
- Understand the clinic is not responsible if my insurance does not reimburse me
- Accept a **$50 fee** may apply for no-shows or late arrivals
- (For minors under 14) A parent or guardian must sign

Signature of patient or parent: _____

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