**Patient Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_

Telephone Number (Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:

Do you give us permission to communicate with you via email or phone?  YES  NO

Date of Birth: \_\_\_\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_\_\_

Month Day Year

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear of us?

**Informed Consent to Foot Care**

I hereby request and consent to routine foot care by Advanced Foot Care Nurse, Vivienne McGaghey, RPN, AFCN on a regular maintenance schedule and that repeated appointments will imply continued consent. I authorize treatment(s) to be administered by appropriate support personnel (Foot Care Students) under the direction of the Foot Care Nurse.

Routine foot care may include but not limited to cutting and filling/ reduction of toenails, care and reduction of calluses and corns, and reduction of involuted (curled) nails, ingrown nails, care and treatment of fungal nails, Ram’s horn nails and plantar warts.

I authorize the review of my personal medical records and permission to communicate or consult to my Family Physician for any relevant information that maybe needed, any of my personal information collected will be kept confidential.

I have read the above consent. I have had an opportunity to ask questions about this consent and all such questions have been answered to my satisfaction.

**Patient Signature:**

**Parent or Guardian Signature:**

(If patient is under the age of 18)

**Witness: Today’s Date:**