DR. RIAR
FOOT & ANKLE CLINIC

Dr. Jaspaul Riar, BSc DPM
#504 – 13737 96th Ave ◆ Surrey, BC ◆ V3V 0C6
TEL: (604) 496-1150 ◆ FAX: (604) 496-2246
www.drriar.com

Name: _____ **Cell/Home #:** _____
LAST, FIRST, MIDDLE *(NICK NAMES)*

Birthday: _____ **Age:**_____ **Sex:** ☐ **M** ☐ **F** **Care Card #:** _____
MONTH / DAY / YEAR

Mailing Address: _____
APT # - STREET, CITY, PROVINCE, POSTAL CODE

Email Address: _____
MOST COMMONLY USED

Extended Benefits: _____ **Occupation:**_____ **Employer:**_____
COMPANY

Emergency Contact: _____ **Tel. #:**_____
NAME / RELATIONSHIP

Family Dr.: _____ **City:** _____ **Tel. #:** _____

How did you hear about us? ☐ Family Doctor ☐ Google ☐ Specialist ☐ Relative / Friend ☐_____

Reason for visit: **How long has it been present?**

MEDICAL HISTORY **Height:** _____ **Weight:** _____ **Shoe Size:** _____

Please ☑ *if you* **HAVE** *or* **HAD** *any of the following:*

☐ Acid Reflux (GERD) / Ulcers	☐ Diabetes (Type I or II?)	☐ Lung Problems
☐ AIDS / HIV	☐ Fibromyalgia	☐ Lupus
☐ Anxiety Disorder	☐ Gout	☐ Migraines
☐ Arthritis (Osteo / Rheumatoid)	☐ Heart Attack (Year :_____)	☐ Osteoporosis
☐ Back Problems	☐ Heart Disease / Problems	☐ Prostate condition
☐ Bleeding Disorders	☐ Hepatitis A / B / C	☐ Psoriasis
☐ Blood Clot	☐ Hernia	☐ Stroke (Year:_____)
☐ Cancer (Type: _____)	☐ High Blood Pressure	☐ Thyroid Condition
☐ Cholesterol (High or Low)	☐ Kidney Problems	☐ Tuberculosis
☐ Circulatory Problems	☐ Liver Problems	☐ Other:

ALLERGIES

☐ Adhesive Tape	☐ Codeine	☐ Metal _____
☐ Anesthetic	☐ Iodine or Shellfish (circle)	☐ Penicillin or Sulfa (circle)
☐ Aspirin	☐ Latex	☐ Other: _____

SOCIAL HISTORY

Currently Pregnant? ☐ Yes ☐ No Smoker: ☐ Yes ☐ No ☐ Former Years smoked: _____

Alcohol: ☐ None ☐ Occasional ☐ Daily Are you claustrophobic? ☐ Yes ☐ No ☐ Slightly

How often do you exercise? ☐ Never ☐ Occasionally ☐ 2x 3x 4x 5x / week ☐ Daily

---

HOSPITALIZATIONS *(include dates):* _____

_____

MEDS *(include over the counter):* _____

I certify that the above information is true and correct to the best of my knowledge. I hereby give permission to Dr. Riar and any qualified staff member to evaluate, diagnose and treat my foot / ankle condition:

Signature of Patient / Substitute Decision Maker: _____ Date: _____

DR. RIAR
FOOT & ANKLE CLINIC

Dr. Jaspaul Riar, BSc DPM
#504 – 13737 96th Ave ◆ Surrey, BC ◆ V3V 0C6
TEL: (604) 496-1150 ◆ FAX: (604) 496-2246
www.drriar.com

Financial Policy

Please read the following in detail and sign the bottom of the page prior to undergoing treatment to avoid any misunderstanding.

EXTENDED HEALTH BENEFITS: If you have a third-party insurance, we will provide you with invoices and/or letters that are necessary **for you to submit your claim**. Our office **does not** submit claims. Payments for the balance owing are due at the time of service and may be made by cash, debit or credit card. Delinquent accounts will be referred to a collection agency.

Once a patient makes an appointment, both time and space have been reserved for that patient. **If you fail to give a minimum of 48 hours notice to cancel or reschedule an appointment or if you do not show up for a reserved appointment time, by signing the below, you understand that you will be charged a cancellation or no-show fee of $50.** This policy allows for mutual consideration of both yours and the physician's time.

Please also note that we DO NOT see WCB patients.

Privacy Policy

Dr. Riar Foot and Ankle Clinic will use and disclose your health information for the following purposes: to help treat you, to assist other health care providers in treating you, to help insurance companies process your claims, to obtain payment for services rendered to you and for certain operational activities, such as quality assessment, licensing, accreditation and training of students and residents. Except as stated in this section, we will not use or disclose your health information without your written authorization.

Do you hereby specifically authorize disclosure of your information to the following people:

Immediate family member	☐ **Yes**	☐ **No**
Family Doctor	☐ **Yes**	☐ **No**
Do you hereby authorize email communication?	☐ **Yes**	☐ **No**

By signing below you confirm that you have read and agree to the terms in **BOTH** the **FINANCIAL POLICY** and the **PRIVACY POLICY** above. By signing below you also confirm that all questions regarding it have been addressed.

PRINT Name of Patient / Substitute Decision Maker : _____

Signature of Patient / Substitute Decision Maker: _____ Date: _____