

# FREE FOOT SCREENING CLINIC

Are you struggling with:

- Runner's Knee
- Stress Fractures
- Ankle Pain or Instability
- Sever's Disease
- Pain
- Fatigue
- Shin Splints
- Plantar Fasciitis

Come for a **FREE** Foot Screening on  
**Day, Date • Time**  
**address • city, state zip**

go to (your website) for details and directions

Please share this invitation with anyone who may be interested!

**000.000.0000**

Call TODAY for an appointment or for more information

LOGO





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# SIGN ME UP FOR THE FREE FOOT CLINIC

## Day and Date • Time

# LOGO

Name

**Adult/Child**

## Shoe Size

**Email (for confirmation)**

## Phone

[illegible]



# FREE FOOT SCREENING CLINIC

Registration Receipt

Day, Date • Time

BRING THIS TO THE CLINIC AND GET  
SPECIAL PRICES ON  
QUADRASTEP® foot orthotics

Tell your friends!

address • city, state zip

go to (your website) for details and directions

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# Refer Patients to our FREE FOOT SCREENING CLINIC

## Day, Date • Time

Are your patients struggling with:

- Runner's Knee
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(Your Company) is a provider of high quality orthotics delivering prefabricated solutions to patients in all age groups.

### THE CLINIC INCLUDES:

- 🦶 FREE FOOT EXAM/GAIT ANALYSIS
- 🦶 TEST FITTING WITH PREFAB ORTHOTICS  
(QUADRASTEPS)
- 🦶 RECOMMENDATIONS FOR FUTURE TREATMENT

Patients interested in registering can call

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LOGO

The clinic will be hosted at

Company Name address, city, state zip  
go to (your website) for details and directions





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- FREE foot exam/gait analysis
- Test fitting with prefab orthotics (QUADRASTEPS)
- Recommendations for future treatment

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logo

## CLINIC REGISTRATION FORM

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ SS#: \_\_\_\_\_

Parent Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent E-Mail Address: \_\_\_\_\_  
For Future Specials/Refurbishment Reminders\*

Person to contact in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_  
(Closest relative not living with you)

Was this due to an accident?    Y    N    Auto \_\_\_\_\_    Work \_\_\_\_\_    Other \_\_\_\_\_

Where were you injured? \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_ Shoe Style: \_\_\_\_\_

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

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

How did you hear about us?:

☐ Mailer    ☐ Poster    ☐ Referred by a friend    ☐ Referred by a practitioner    ☐ Website

☐ Email    Name of website/Practitioner: \_\_\_\_\_

Patient or Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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