

PATIENT INFORMATION

PLEASE PRINT IN ALL SPACES.

THIS INFORMATION IS REQUIRED IF WE ARE TO FILE YOUR CLAIM.

NAME _____ DATE _____

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ WK PHONE _____ SS# _____

CELL PHONE _____

DATE OF BIRTH _____ AGE _____ SEX M F MARITAL STATUS S M W D SEP

REFERRED BY _____ PERSONAL PHYSICIAN _____

PATIENT'S EMPLOYER _____ OCCUPATION _____

SPOUSE'S SPOUSE'S SPOUSE'S

NAME _____ EMPLOYER _____ WK PHONE _____

PERSON RESPONSIBLE FOR BILL

(IF OTHER THAN PATIENT)

NAME _____ RELATIONSHIP _____

ADDRESS _____ HOME PHONE _____

DOB _____ EMPLOYER _____ POSITION _____

WK PHONE _____ SS# _____

INSURANCE COMPANY INFORMATION

POLICY HOLDER INFORMATION

INSURED'S NAME _____ DOB _____

COMPANY _____ INSURED SS# _____

GROUP NUMBER _____ POLICY NUMBER _____

SECONDARY CARRIER INFORMATION

(IF APPLICABLE)

COMPANY _____ INSURED SS# _____

GROUP NUMBER _____ DOB _____ POLICY NUMBER _____

NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY

(IF NOT ALREADY LISTED)

NAME _____ RELATIONSHIP _____

EMPLOYER _____ PHONE NUMBER _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO FOOT & ANKLE HEALTH CENTER, WHEN APPLICABLE. I ALSO AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR SERVICES RENDERED. ALL VISITS AND PROCEDURES ARE HANDLED ON A CASH BASIS AT THE TIME SERVICES ARE PROVIDED. FOR YOUR CONVENIENCE, YOU MAY PAY BY CASH, PERSONAL CHECK, OR CREDIT CARD. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

SIGNATURE _____ DATE _____

MEDICAL INFORMATION

Describe your foot problem

How long has it been bothering you? ___ Days ___ Weeks ___ Months ___ Years

Describe any past problems with your feet and/or ankles:

Please list/Circle activities you enjoy walking, cycling, running, tennis, golf, other: _____

Shoe Size _____ Current Weight _____ Current Height _____

ALLERGIES:

Are you **allergic** or **sensitive** to?

Penicillin, Sulfa or antibiotics? _____

Any Medicines? _____

Tape? _____

Betadine, Iodine? _____

Any **METAL** allergy? _____

Other: _____

Have you had any problems taking aspirin or ibuprofen (Advil, Motrin, or Aleve)? _____

Any problems with local anesthetics (Novocaine, Lidocaine)? _____

Are you on blood thinners (Coumadin, Plavix)? _____

GENERAL HEALTH INFORMATION

Do you have Diabetes? YES ___ NO ___ If yes, do you take insulin? YES ___ NO ___
Number of years _____

List any **illnesses** or **medical conditions**: _____

List any major **surgeries**: _____

Are you under a physician's care? YES ___ NO ___ If yes, for what condition? _____

Family Physician: _____ Date you last saw this doctor: _____

May we contact your physician about your health? YES ___ NO ___

Name of your pharmacy or drugstore: _____ Phone Number: _____

Please list your current medications:

Check () any of the following you have, or have had a problem with:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Heart | <input type="checkbox"/> Asthma | <input type="checkbox"/> Skin | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Circulation | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Gout | <input type="checkbox"/> Frequent infections |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hormones | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Healing |
| <input type="checkbox"/> Kidneys | <input type="checkbox"/> Anemia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Neurological disorder |
| <input type="checkbox"/> Lungs | <input type="checkbox"/> Bladder | <input type="checkbox"/> Liver | <input type="checkbox"/> Intestines |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blood clots/Phlebitis | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Hepatitis, Please circle type A,B,C,D | | | |

Do you have any artificial joints?

Hip YES___ NO___
Knee YES___ NO___
Other _____

Do you have a Heart Valve Implant? YES___ NO___

FAMILY HISTORY

Mother	Living_____	Deceased_____	Cause of Death_____
Father	Living_____	Deceased_____	Cause of Death_____
Brother	Living_____	Deceased_____	Cause of Death_____
Sister	Living_____	Deceased_____	Cause of Death_____

Is there a family (blood relative) history of?

- | | |
|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Circulation Problems in Legs or Feet |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Blood Clot in Leg (DVT or Phlebitis) |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Foot Problems List: _____ |
| <input type="checkbox"/> Neurological Disorder | |
| <input type="checkbox"/> Stroke | |

SOCIAL HISTORY

Do you smoke? _____ Number of packs per day_____

Have you previously smoked? YES___ NO___ Number of years _____

Do you drink alcohol or beer? YES___ NO___ How much? Light usage () Moderate () Heavy ()

Employment: () Sits at job () Stands at job () Stands and walks at job () Retired

Signature: _____ Date: _____