Patient Information

Date:_____ SSN:_____ Birth Date: _____

Name:_____
Last Name First Name Initial

Address:_____

City:_____ State:_____ Zip:_____

Home #:_____ Cell #:_____ Email:_____

Sex: ☐M ☐F ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Ethnicity : Caucasian African American Asian Latino Other : _____

Employer: _____ Business Phone:_____

Pharmacy: _____ Phone number: _____

Emergency Contact: _____ Phone #:_____

Who is your Primary Care Doctor? (First/last name) _____

Phone number : _____ Date last seen : _____

Who may we thank for referring you?_____

Insured Information

Primary Insurance:_____

Subscriber Name: _____ Sex: ☐Male ☐Female

Subscriber DOB: _____ Subscriber SSN: _____

Relationship to insured: ☐Spouse ☐Child ☐Self ☐Other

Secondary Insurance:_____

Subscriber Name: _____

Subscriber DOB: _____ Subscriber SSN: _____

Relationship to insured: ☐Spouse ☐Child ☐Self ☐Other

I, _____ acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices.

_____ _____
Signature of Patient or Authorized Representative Relationship to Patient (if applicable)

I hereby authorize payment directly to Feet First Podiatry of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I understand that I am financially responsible for any collection fee should I default on any patient balances. I authorize the above doctor and/or provider or supplier of services in this office to release the information required to secure the payment or benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party:_____

History and Physical

Name:_____

Height: _____ Weight: _____ Shoe Size: _____

OFFICE USE:

BP=____/____ PULSE=_____

List of Current Medications:

_____

_____

_____

_____

Allergies:

_____

_____

Medical History:

○ Allergies	○ Anemia	○ Anxiety	○ Arthritis	○ Asthma
○ Back Pain	○ Blood Clots	○ Bleeding Problems	○ Breathing Problems	○ Cancer (type) _____
○ Circulation Problems	○ Depression	○ Diabetes *Type 1 Type 2*	○ Emphysema	○ Fibromyalgia
○ Gout	○ Heart Disease	○ Heart Murmur	○ Hepatitis	○ High Cholesterol
○ High Blood Pressure	○ HIV	○ IBS	○ Kidney Disease	○ Liver Disease
○ Mental Illness	○ Neuropathy	○ Psoriatic Arthritis	○ Rheumatoid Arthritis	○ Restless Leg Syndrome
○ Sleep Apnea	○ Skin Disorders	○ Stroke		○ Other (specify) _____ _____ _____

Are You Pregnant? Yes No **Are You Nursing?** Yes No

Surgical History:

○ NONE	○ Adenoids	○ Angioplasty	○ Appendix	○ Cataracts
○ Colonoscopy	○ C-Section	○ Gallbladder	○ Heart Bypass	○ Heart Stent
○ Hip Replacement	○ Teeth	○ Tonsils	○ Tumor Removal	○ Other: _____ _____ _____

Have you ever had any surgical procedure on your foot/ankle? Yes No

If yes, please describe: _____

_____

Do you have any artificial joints? No Yes , Where?_____

Do you have an artificial heart valve? No Yes

Family History: *is there any family history of the following?*
Please specify whether it is your mother, father, or other family member.

- o Arthritis
- o Asthma
- o Bleeding Problems
- o Blood Clot
- o Cancer
- o Diabetes *Type 1 Type 2*
- o High Blood Pressure
- o Heart Disease
- o Kidney Disease
- o Liver Disease
- o Other (specify)

_____

Social History:

Do you drink alcohol? No Rarely Socially Everyday

Do you drink caffeinated beverages? No Yes, How much? _____

What is your occupation? _____

Do you exercise regularly? No, I do not. Yes. I do the following regular exercise.

_____

Substance Abuse: No Yes, I have a current substance abuse problem.

Please specify: _____

Do you smoke? No Yes Former

If yes, how many packs per day? ½ 1 2 3 4 How long? _____

Review of Systems: *(Please check the box if you currently have any of these symptoms or check "NONE")*

Cardiovascular	o Ankle Swelling o Cold Feet/Hands	o Leg Pain o Leg Swelling	o Palpitations o Vascular Disease	o **NONE**
Gastrointestinal	o Abdominal Pain o Blood in Stool o Constipation	o Decreased Appetite o Diarrhea	o Heartburn o Vomiting o Ulcers	o **NONE**
Genitourinary	o Blood in Urine o Decreased Urination	o Excessive Urination o Kidney Stones	o Incontinence o Painful Urination	o **NONE**
Integumentary	o Athletes Foot o Callus/Corns o Cracked Heels	o Ingrown Toenail o Keloids o Nail Changes	o Nail Fungus o Ulcers o Warts	o **NONE**
Musculoskeletal	o Ankle Pain o Arch Pain o Ball Pain	o Bottom of Foot Pain o Flat Feet	o Heel Pain o Toe Pain o Top of Foot Pain	o **NONE**
Neurological	o Numbness o Paralysis	o Seizures o Tingling/Burning	o Tremors o Weakness	o **NONE**
Respiratory	o Chest Pain o COPD	o Coughing o Shortness of Breath	o Wheezing	o **NONE**

What is the reason for your visit today?

_____

_____

On a scale of 1-10, how would you rate your pain (1 being no pain to 10 being the worst): 1 2 3 4 5 6 7 8 9 10

How long has this bothered you?_____

What treatments have you tried and have they been effective?

_____

The pain quality is: burning constant dull sharp shooting throbbing tingling tearing

Other:_____

What make the pain worse? Running Walking Standing Certain Shoes Elevation Touching/Rubbing

Other:_____

Have you experienced any trauma or injury to the area?

_____

_____

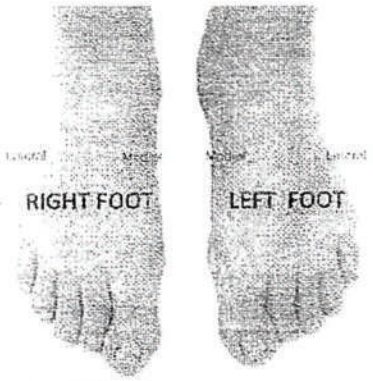
Is this condition the result of an event at work? No Yes

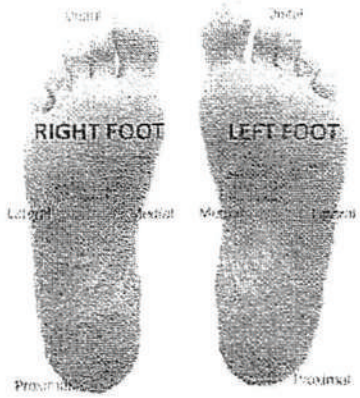
If yes, have you notified your employer and the worker's compensation liaison at your place of employment?_____

What is their contact information?

_____

Please circle where on your feet/ankles you are having pain.





PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature:_____ Date:_____