PATIENT INFORMATION

NAME: _____ DATE: _____

ADDRESS: _____CITY:_____STATE:_____ZIP:_____

PRIMARY PHONE: _____ WORK PHONE: _____

Is it okay to leave a message on your phone? Yes ☐ No ☐ CELL PHONE: _____

SEX: Male ☐ Female ☐ DATE OF BIRTH: _____ AGE: _____SOCIAL SECURTIY NO: _____

MARITAL STATUS (CIRCLE ONE) M S W D SEP SPOUSE'S NAME: _____

RACE: ☐ White ☐ Black ☐ Native American ☐ Asian ☐ Native Hawaiian ☐ Other Polynesian

☐ More than one race ☐ Unknown/Other/Prefer not to say

PREFERRED LANGUAGE: _____ ETHNICITY: ☐Not Hispanic or Latino ☐Hispanic or Latino

REFERRED BY: _____ PRIMARY DOCTOR: _____

PATIENT'S EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ EMERGENCY PHONE #: _____

RELATIONSHIP TO PATIENT: _____

RESPONSIBLE PARTY (If applicable)

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE NUMBER: _____

INSURANCE INFORMATION (please have insurance cards and photo ID available)

COMPANY	INSURED NAME	RELATIONSHIP	INSURED ID#	INSURED BIRTHDATE	GROUP #
1.					
2.					

COPAY AMOUNT: _____ INSURANCE DEDUCTIBLE: _____

HOW MUCH OF YOUR DEDUCTIBLE HAS BEEN MET? _____ ☐ SELF PAY (PLEASE MAKE PAYMENT ARRANGEMENTS PRIOR TO VISIT)

PATIENT NAME: _____

MEDICAL INFORMATION

This information is important for our records and your health

Describe your foot problem:

Right: _____

_____

Left: _____

_____

How long has it been bothering you? Days_____ Weeks_____ Years_____

Have you had any past problems with your feet or ankles? _____

_____

_____

Shoe Size: _____ Current Weight: _____ Height: _____

Are you taking aspirin? _____ Pharmacy: _____

Are you allergic to, or have you ever had a reaction to any of the following?

NAME	YES	NO	TYPE OF REACTION
Antibiotics/Penicillin			
Aspirin			
Bandage/tape			
Hydrocodone			
Iodine			
General Anesthesia			
Latex			
Lidocaine/Novocain			
Sulfa Drugs			
Other (please specify)			
Other (please specify)			
Other (please specify)			
Other (please specify)			
Other (please specify)			

PATIENT NAME: _____

Medications you are currently taking:

Medication Name	Dosage	Times per day	Reasons for taking this medication

Do you have Diabetes? ☐ Yes ☐ No If yes, are you taking insulin? ☐ Yes ☐ No How many years? _____

Are you being treated for or have you been treated for any of the following? (check all that apply)

☐ Alcoholism	☐ Anemia	☐ Anxiety	☐ Arthritis
☐ Asthma	☐ Bi-polar	☐ Bronchitis	☐ Cancer/tumor
☐ Cholesterol	☐ COPD	☐ Dementia	☐ Depression
☐ Drug Abuse	☐ Emphysema	☐ Epilepsy	☐ Fibromyalgia
☐ GERD	☐ Gout	☐ Glaucoma	☐ Heart Attack
☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure	☐ Hiatal Hernia
☐ Insomnia	☐ Lupus	☐ Migraines	☐ Osteoporosis
☐ Prostate	☐ Psoriasis	☐ Rheumatoid Arthritis	☐ Seizure
☐ Sleep Apnea	☐ Stomach Ulcers	☐ Stroke	☐ Thrombophlebitis
☐ Thyroid Disease	☐ Tuberculosis	☐ Urinary Incontinence	

Are you currently pregnant? Yes _____ No _____ Due Date _____ Are you nursing? Yes _____ No _____

Please List all surgeries, diagnostic tests, or procedures that required anesthesia:

_____

_____

NAME: _____

Have you had any of the following? (Check all that apply)

GENERAL
- ☐ Recent weight loss
- ☐ Recent weight gain
- ☐ Chills
- ☐ Fever
- ☐ Night Sweats
- ☐ Excessive Tiredness
- ☐ Hospitalization within the last 5 years

If yes why? _____

HEAD, EYES, EARS, NOSE, THROAT
- ☐ Blurred Vision
- ☐ Hearing Problems
- ☐ Sinus Problems
- ☐ Glasses
- ☐ Contacts
- ☐ Sore throat
- ☐ Double vision
- ☐ Nose bleeds
- ☐ Dizziness

SKIN
- ☐ Eczema
- ☐ Skin Rash
- ☐ Athlete's foot
- ☐ Sweaty feet
- ☐ Change in Moles
- ☐ History of foot ulcers

RESPIRATORY
- ☐ Use of a C-PAP
- ☐ Shortness of breath
- ☐ Use of oxygen
- ☐ Cough
- ☐ Wheezing
- ☐ Difficulty breathing

CARDIOVASCULAR (heart)
- ☐ History of heart attack
- ☐ Irregular heart rate
- ☐ Chest pain
- ☐ Calf pain when exercise
- ☐ Legs give out if walking
- ☐ Poor Circulation
- ☐ Swelling (ankles/legs)

GASTROINTESTINAL
- ☐ Acid reflux
- ☐ Vomiting
- ☐ Blood in stool
- ☐ Diarrhea
- ☐ Constipation
- ☐ Nausea

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Early a.m. joint pain
- ☐ Low back pain
- ☐ Numbness in feet
- ☐ Prior foot/ankle fracture
- ☐ Joint swelling or pain

NEUROLOGICAL/PSYCHIATRIC
- ☐ Fainting
- ☐ Confusion
- ☐ Speech problems
- ☐ Neuropathy
- ☐ Poor balance

ENDOCRINE
- ☐ Excessive sweating
- ☐ Often feeling cold
- ☐ Frequent urination
- ☐ Often hungry
- ☐ Prostate problems

HEMATOLOGICAL
- ☐ Bleeding problems
- ☐ Blood clot in legs
- ☐ Blood clot in lungs
- ☐ Lump in groin
- ☐ Lump in arm pit
- ☐ Swollen glands

IMMUNOLOGICAL (immune system)
- ☐ Frequent infections
- ☐ Slow healing
- ☐ History of MRSA
- ☐ HIV/AIDS

Do you have any artificial joints? (Please list all) _____

Do you have a Heart Valve Implant? _____

FAMILY HISTORY

Is there a family (blood relative) history of:

- ☐ Anesthesia reactions
- ☐ Arthritis
- ☐ Bleeding disorders
- ☐ Bunions
- ☐ Cancer
- ☐ Circulation problems
- ☐ Diabetes
- ☐ Flatfeet
- ☐ Hammer toes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Malignant hypertension
- ☐ Neurological disorder
- ☐ Rheumatoid problems
- ☐ Stroke

NAME: _____

Mother	Living _____	Deceased _____	Cause of death_____
Father	Living _____	Deceased _____	Cause of death_____
Sister	Living _____	Deceased _____	Cause of death_____
Brother	Living _____	Deceased _____	Cause of death_____

SOCIAL HISTORY

Recreational activities: _____

Do you Smoke? Yes ___ No___ If yes, how many packs per day? _____ How long have you been smoking? _____

Have you previously smoked? Yes___ No____ How many years did you smoke? _____

Do you drink alcohol (including beer/ wine)? Yes _____ No____ If yes, how many times per week _____

Do you exercise regularly? Yes_____ No _____

At your place of employment, do you: (check all that apply)

☐ Sit at job ☐ Stand at job ☐ Stand and walk at job ☐ Have a required shoe type

AUTHORIZATIONS

CONSENT FOR TREATMENT: I authorize necessary medical care to be rendered to the patient registered hereon. (Initial) _____

FINANCIAL AGREEMENT AND RELASE OF INFORMATION: I authorize the release of my personal health care information that might be required for processing my insurance claims by insurance companies through which I am covered, or any subsequent insurance companies from which I obtain coverage. (Initial) _____

I understand that my services will be billed to my insurance company(s) provided. I have given proof of my insurance coverage at the time services are rendered. If I do not have proof of insurance coverage at the time services are rendered, I understand that payment is due at the time of service. **I will promptly pay all amounts that have been determined my responsibility within 30 days of notification, or will discuss a payment plan with the billing department.** If I am *over* 18, I am ultimately responsible for any patient balance for services I received. If I am *under* the age of 18, my parent or legal guardian is responsible for my patient balance until my 18th birthday. (Initial) _____

I understand that it is my responsibility to coordinate my benefits with my insurance company(s). I am ultimately responsible for copays, deductibles, authorizations, eligibility, and etc. (initial) _____

ACKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I was referred to the Notice of Privacy Practices information page and that I have read (or had the opportunity to read if I so chose) and understand the Notice. (Initial) _____

Patient Signature _____**Date:** _____

Signature of Parent/ Legal Guardian _____ **Date:** _____