THE FOOT
Podiatry

Please bring with you:
- Insurance card
- Photo ID
- Medication list

PATIENT INFORMATION SHEET

Name_____ Patient Social Security Number_____

Date of Birth ____/____/____Email address: _____

Primary Care Dr. _____ Gender: M / F Ethnicity_____

How did you hear about us? _____

Mailing Address:_____ City _____ State_____ Zip _____

Home Phone Number ( ) _____ Cell Phone Number ( ) _____

Emergency Contact: _____ Phone#_____

Pharmacy Name_____ Phone#_____

▶**Reason for your visit today?**

_____

Tell me about your pain:

How long have you had this problem? _____ Days / Weeks / Months / Years

Did your pain or problem: □ Begin all of a sudden □ Gradually develop over time

How would you describe your pain? □ No Pain □ Sharp □ Dull □ Aching □ Burning □ Radiating

□ Itching □ Stabbing □ Other:_____

How would you rate your pain on a scale from 1-10? (Circle Please)

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)

Since the time you pain or problem began, has it: □ Stayed the Same □ Became Worse □ Improved

Where is the pain/problem located?

_____

Does anything make the pain or problem feel worse?

_____

Does anything make your pain or problem feel better?

_____

What treatments have you had for this problem?

_____

Was this problem caused by an injury? □ Yes (Describe) □ No

_____

If yes, was it a work-related injury? □ Yes □ No

Allergies _____

▶Current Medications

□ None or See List Below (or attach list)

Medication Name	Dose (mg, units, etc)	How Often/When

▶Patient Medical History

Have you been diagnosed with any of the following? Please circle all that apply:

Anemia	Chronic Obstructive Pulmonary Disease	Osteoporosis
Angina or chest pain	Diabetes	Rheumatoid Arthritis
Asthma	Lymphodema	Hepatitis or Liver Disease
AIDS/HIV	High Cholesterol	Stroke or Transient Ischemic Attack
Hypertension	Heart Attack	Kidney Disease
Cancer	Gout	Drug Abuse Disorder
Congestive Heart Failure	Arthritis	Deep Vein Thrombosis
Coronary Artery Disease	Sleep Apnea	Dialysis
Depression	Gastric Ulcer	Peripheral Arterial Disease

▶ List any previous foot or ankle surgeries

_____

▶Family History

□ Stroke □ Arthritis □ Cancer □ Diabetes □ Heart Disease □ High Blood Pressure

▶Social History

- Use of Alcohol? □ No □ Yes (If yes, how much/frequently?_____
- Use of Tobacco? □ No □ Yes (If yes, how much/frequently?_____

▶Vitals

Weight_____ Height_____ Shoe Size_____

FINANCIAL RESPONSIBILITY:

I am aware that benefits are determined by my insurance company and not by the provider. Verification of benefits is not a guarantee of payment, and I will be responsible for any portion of my treatment that is not covered or is denied by the insurance company including my co-payments, deductibles, and co-insurance. I understand that all co-pays and service charges that are not covered by my insurance company will be due at the time of service. I understand the provider is not responsible for the misquotation of benefits form my insurance company. Insurance benefits are determined by my insurance company when the claim is received.

HIPAA DISCLOSURE/AUTHORIZATION TO RELEASE INFORMATION:

My signature below denotes my acceptance of Podiatric medical care. I authorize release of information to my referring physician or other providers as a necessary part of the course of medical diagnosis and treatment. Authorization is also given to release information to insurance companies necessary to the completion of insurance claims, review of services or receipt of benefits.

_____

Printed Patient's Name

_____ _____

Patient Signature (Parent or Guardian if patient under 18 years old) Date