THE FOOT
Podiatry

PATIENT INFORMATION

Name_____ Patient Social Security Number_____

Date of Birth _____/_____/_____ Email address: _____

Gender: M / F Ethnicity _____

Mailing Address: _____ City _____ State_____ Zip _____

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

Emergency Contact: _____ Phone#_____

Relationship: _____

Primary Care Dr. _____

Pharmacy Name_____

Address:_____ Phone#_____

▸**How did you hear about us?** _____

☐ I will be using insurance for my appointment(s). **(DO NOT FILL OUT IF YOU HAVE PROVIDED YOUR INSURANCE CARD TO THE FRONT)**

Insurance carrier: _____ Member ID: _____

Policy holder: _____ Policy holder's DOB: _____ Group: _____

☐ I will be self-paying for my appointment(s).

▸ **Reason for your visit today:** _____

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 your 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? ☐ No ☐ Yes (Describe) _____

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

Allergies: _____

▸ **Current Medications**: ☐ None ☐ See Attached 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 Angina or chest pain Asthma AIDS/HIV Arthritis Cancer COPD Congestive Heart Failure Coronary Artery Disease Deep Vein Thrombosis Depression Diabetes Dialysis Drug Abuse Disorder Gastric Ulcer Gout Heart Attack Hepatitis or Liver Disease High Cholesterol Hypertension Kidney Disease Lymphedema Osteoporosis Peripheral Artery Disease Rheumatoid Arthritis Sleep Apnea Stroke or Transient Ischemic Attack

▸ **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**

Height: _____ Weight: _____ 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 from 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 Date

(Parent or Guardian if patient under 18 years old)