Family Foot & Ankle Specialists

PATIENT INFORMATION

Date: ______________________________________
Patient Name: _______________________________
Address: ____________________________________
City: ________________ St: ________ Zip: _________
E-Mail: _____________________________________

Sex ☐ M ☐ F Age: ________ DOB: __________
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced

Home Phone: _________________________________
Cell Phone: __________________________________

How did you hear about us? ___________________

Emergency Contact
Name: _____________________________________
Phone #: ___________________________________
Relationship: ________________________________

Patient
Employer/School: ____________________________
Employer Phone: _____________________________
Spouse's Name: ______________________________
Birth Date: _______________________
SSN: ____________________________

INSURANCE INFORMATION

Who is responsible for this account:

____
Relationship to patient: _____________________
Primary Insurance Co: _______________________
ID#: _______________________________________
Group#: ____________________________________
Policy Holders Name: ________________________
Birth Date: ___________________

Is patient covered by a secondary insurance?
☐ Yes ☐ No
Secondary Insurance: _________________________
ID#: ______________________________________
Group#: ____________________________________
Policy Holders Name: _________________________
Birth Date: ___________________
SSN: ________________________

INSURANCE ASSIGNMENT AND RELEASE

I certify I have insurance coverage with:

____

and assign directly to Family Foot and Ankle Specialists. All insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Family Foot & Ankle Specialists may use my health care information and may disclose such information to the above-named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____
Signature of Patient, Guardian, or Personal Representative

__________ ____________________________
Date Relationship to Beneficiary

Today's chief complaint ____________
____
____
Have you ever been treated by a Podiatrist before? _______________
If yes, please list.
Name: ___________________
Last visit: ________________
Shoe size: _______
Weight: ________
Height: _________

Is this injury/problem related to:
Work ☐ YES ☐ NO
Car Accident ☐ YES ☐ NO
Personal Injury Case ☐ YES ☐ NO

Is there any personal, or family history of diabetes? ☐ YES ☐ NO

Cigarette/Tobacco use: ______________
Years Smoked: ____________________

Athletic activities in which you participate (please list if applicable):
____
____

What type of pain are you experiencing?
☐ Numbness ☐ Throbbing
☐ Stabbing Pain ☐ Burning
Pain level 1-10: __________
How long has this problem occurred? _______

Please indicate which foot problems you have now or have had in the past.

Problem		
Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Calluses	☐ Yes	☐ No
Numbness/Tingling	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Heel Pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Plantar Warts	☐ Yes	☐ No
Swelling in ankles or feet	☐ Yes	☐ No

Please **CIRCLE** to indicate if you have had any of the following:

Allergies to Anesthetics
Allergies to medicine or drugs
Anemia
Angina
Arthritis
Artificial heart valve(s)
Artificial joints
Asthma
Back problems
Bleeding disorders
Cancer
Chemical dependency
To what? _____________

Chest pain
Chronic diarrhea
Circulatory problems
Diabetes
Years: ____ *Type:* ___
Ear problems
Epilepsy
Eye problems
Fainting
Gout
HIV
Headaches/migraines
Heart disease

Hepatitis/jaundice
Type: ____ *When:* _______
High Blood Pressure
Kidney disease
Liver disease
Low blood pressure
Neuropathy
Pacemaker
Phlebitis
Problems taking aspirin products
Psychiatric care
Radiation treatment
Rash

Respiratory disease
Rheumatic fever
Shortness of breath
Sinus problems
Special diet
STD
Stroke
Swollen neck glands
Thyroid disease
Tuberculosis
Ulcers
Varicose Veins
Weight Loss, unexplained

Surgical history: ____
____

Hospitalization other than for surgeries listed above: ___________________________________
____

Family Physician: _________________________________ Date of Last Visit: _____________________

Are you now, or have you been, under a doctor's care for any reason in the past 12 months?

☐ YES ☐ NO

If yes, please explain: ____

MEDICATIONS

Include prescriptions, over-the counter medications, and vitamins: ______________________________________
____
____
Pharmacy name: _______________________________
Pharmacy phone #: _____________________________
Do you take oral contraceptives? ☐ Yes ☐ No
Do you take any blood thinners? ☐ Yes ☐ No

ALLERGIES

___ Adhesive tape
___ Novocain
___ Penicillin
___ Codeine
___ Local / Anesthetic
___ Demerol
___ Iodine
___ No Known Drug Allergies
___ Aspirin
___ Anticoagulant therapy
___ Sulfa
___ Seafood

Other: ______________________________________
____
____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistant or designated replacement) to administer and perform such procedures upon name as the doctor deems necessary.

____ ____________________________________
Signature of Patient, Parent, Guardian or Personal Representative Date

____

Printed Name

FAMILY FOOT & ANKLE SPECIALISTS

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