

WELCOME

PATIENT INFORMATION

Name: _____
I prefer to be called: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone
(____) _____
Work Phone
(____) _____ ext. _____
Cell Phone
(____) _____
Email Address: _____
Do you want reminders sent to email? __ Yes __ No
The best time to contact me
is: _____ A.M. P.M. by
 Home phone Work phone Cell phone Email
Date of Birth: _____
SS# : _____
Gender: Female Male
Marital Status:
 Minor Single Married Widowed
 Divorced Fiancé Separated
Primary Care Physician

Phone # _____
Fax # _____
Date Last Seen _____

Emergency Contact Name: _____
Relationship _____
Home Phone _____
Work Phone _____

RESPONSIBLE PARTY

Self – Employer Name & Address:

Occupation

Phone:
(____) _____
If not Self - Relationship to Patient:
 Parent Spouse Other _____
Name: _____
SSN# _____ Date of Birth: _____
Gender: Female Male
Address: _____
City: _____
State: _____ Zip: _____
Phone:
(____) _____

Co-Pay \$ _____
INSURANCE INFORMATION

Primary Insurance Company:

ID# _____
Group # _____
Name of Insured (if not self):

SSN#: _____ Date of Birth: _____
Relationship to Patient
 Spouse Parent Other _____
Gender: Female Male

DO YOU HAVE ANY ADDITIONAL INSURANCE?

Yes No

IF YES, COMPLETE THE FOLLOWING

Secondary Insurance Company:

ID# _____

Group # _____

Name of Insured: (if not self)

SSN#: _____ Date of Birth: _____

Relationship to Patient (If not self):

Spouse Parent Other _____

Gender: Female Male

Name of Employer:

Primary Pharmacy

City: _____ Zip: _____

Phone #: _____

Secondary Pharmacy

Address: _____

City: _____ Zip: _____

Phone: _____

RESPONSIBLE PARTY FOR PATIENT UNDER 18

Relationship to Patient:

Parent Other _____

Accompanying Adult Name:

Signature

Language

Primary Language: Arabic Chinese English French Italian Japanese

Portuguese Russian Spanish Other

Secondary: Arabic Chinese English French Italian Japanese

Portuguese Russian Spanish Other

RACE

Race: American Indian or Alaskan Native Asian Black or African American

Native Hawaiian or Pacific Islander White Other _____

ETHNICITY

Ethnicity: Hispanic or Latino Not Hispanic or Latino

TOBACCO USE

Smoking Status? No -----YES Current Smoker every day, or Current Smoker some days

Former Smoker ---- how many packs per day: _____ and how many years _____

Never have smoked

Whether my insurance is Medicare or any other type of carrier, I hereby assign, and set over to The Foot Center, Inc all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy for services billed by this office on my behalf. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I revoke said authorization by giving written notice. I understand that I am financially responsible for all charges whether or not they are covered.

Patient Signature _____ or Parent or Guardian

Alcohol use? No Yes __How much daily _____

Caffeine use ? No Yes __How much daily _____

MEDICAL HISTORY

What is the chief complaint for which you came to be treated?

SURGERY HISTORY

No prior surgical history
 Heart Bypass Heart Valve Repair / Replacement Appendectomy
 Brain Surgery Gall Bladder Mastectomy
 Other _____

How would you describe your pain on a scale of 1 to 10? _____

Have you ever been to a Podiatrist before? Yes No If yes, when _____

Describe your pain: Sharp Aching Throbbing Shooting Electrical Sensation
 Pins & Needles Burning Numbness

Location of pain or primary complaint(Right or Left): Lower Leg Ankle Achilles Tendon
 Heel Midfoot Arch Forefoot Sole of foot Ball of Foot
 Top of Foot Big Toe Lesser Toes Toenails Other

How long has your problems been present: 1-3 days 3-7 days 1-3 weeks 3-6 weeks
 6-8 weeks 3-6 months 6-9 months 9-12 months greater than 1 year

Onset of condition or injury: Gradual onset over time Sudden onset from activity or injury

Course / Progression of Condition: Severe Worsening Moderate Worsening
 Mild Worsening Steady / Unchanging Mild Improvement Moderate Improvement
 Considerable / Good Improvement

Pain / Condition aggravated by: Any weight bearing Standing Walking Running
 Exercise Bending Stooping Pressure to ball of foot Pressure from shoes
 Pressure from jumping

Have you attempted any treatments to relieve your problem? Yes No If yes,how?

- Rest Ice Elevation Change shoe Gear Over the Counter Padding
 Over the Counter Anti-Inflammatory Medication (Motrin, Aleve, Tylenol, Aspirin, etc.)
 In Home Whirlpool Stretching Trimming Out Toenail Yourself Applying Skin Cream
 Applying Topical Antibiotic Ointment (triple antibiotic, Bacitracin, Neosporin, etc.)

How much improvement and relief have you achieved with previous treatments: Mild Improvement
 Moderate Improvement Considerable Improvement No Improvement Worsening of Condition

What is your activity level at work: Sitting Standing Walking
 Considerable Movement / Walking Retired Heavy Lifting

Athletic activities which you participate:

PAST MEDICAL HISTORY

Place a check mark next to any of the following that pertain to your medical history

- Hypertension / High Blood Pressure HIV / AIDS Hepatitis Heart Attack / MI
 Insulin Dependent Diabetes Non-Insulin Dependent Diabetes Stroke / CVA
 Aneurysm Blood Clot

Gastrointestinal

- Reflux / Heart Burn Ulcer Abdominal Pain
 Liver Disorder Hepatitis A Hepatitis B
 Hepatitis C Excessive Hunger Excessive Thirst
 Loss of Appetite Colitis

Hematological

- Anemia Sickle Cell Disease or Trait Cancer Cancer / Leukemia Blood Transfusion

Hematological- Have you been anticoagulant with any of the following blood thinners?

- Coumadin Heparin Aspirin Plavix

Endocrine

- Diabetes Thyroid Disease

Musculoskeletal

- Arthritis / Degenerative Joint Disease Rheumatoid Arthritis Gout
 Back Pain Hip Pain Knee Pain Frequent Muscle / Tendon Pain

Musculoskeletal- Do you have any of the following joint replacements / prosthesis:

- Hip Knee Ankle Hands Feet Spine

Date of Joint Replacement: _____

Immunology

- HIV Frequent Infections / Weak Immune System Chronic Fatigue Syndrome / Epstein Barr

Past Medical History-Injuries / Trauma:

Have you had any of the following foot surgeries?

- Toenail Bunion Hammertoe Fracture Repair Joint Fusions
 Tendon Repair / Rerouting Ankle Stabilization Arthroscopy Fasciotomy

Are you pregnant? Yes No If yes, when are you due? _____

HOSPITALIZATIONS

Please list Hospitalizations not including Surgeries?

Are you now, or have you been, under any other doctor's care for any reason over the past two years?

- Yes No If yes, please explain:

MEDICATIONS

(INCLUDE PRESCRIPTIONS, OVER THE COUNTER & VITAMINS – Please list dosage and strength)

ALLERGIES (INCLUDE FOOD AND PLANT)

<input type="checkbox"/> No known allergy history	<input type="checkbox"/> Demerol	<input type="checkbox"/> Novocaine
<input type="checkbox"/> Adhesive/Tape	<input type="checkbox"/> Iodine	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Anti-coagulant	<input type="checkbox"/> Latex	<input type="checkbox"/> Seafood
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Codeine	<input type="checkbox"/> Erythromycin	
<input type="checkbox"/> Cortisone		
<input type="checkbox"/> Other		

PRIVACY POLICY

Notice of Privacy Practices Acknowledgement

I, _____, acknowledge receiving on
(Patient's name)

_____ a copy of The Foot Center, Inc Notice of Privacy Practices.
(Date)

Patient Signature X _____