

# Welcome to Our Office!

**Patient Information** Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Sex: M F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: S M D W  
Driver's License No: \_\_\_\_\_ Social Security No: \_\_\_\_\_

**Employer** Employer: \_\_\_\_\_ Work No: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Spouse/ Guarantor Information** Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ Phone No: \_\_\_\_\_  
SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Driver's License No: \_\_\_\_\_

**Referral** \_\_\_\_\_ Doctor \_\_\_\_\_ Friend \_\_\_\_\_ Other  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_

## Insurance Information

Group Insurance Coverage:

<u>Primary Carrier</u>	<u>Other Carrier</u>
Insured: _____	Insured: _____
Insurance Co: _____	Insurance Co: _____
Group: _____ ID: _____	Group: _____ ID: _____
Phone no. to verify: _____	Phone no. to verify: _____
Medicare No: _____	Effective Date: _____

## Our Goals

*We are dedicated to helping your feet last a lifetime with as little or no pain as possible on a permanent basis. It is important that you answer all questions as thoroughly as you can.*

**ALL CHARGES INCURRED ARE DUE AND PAYABLE AT THE TIME OF THE VISIT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.**

I hereby give my permission for the doctor to render the proposed Podiatric examination and treatment. I understand that I am financially responsible to the Physician for all charges incurred by me or my dependents, and further, I authorize the release of any medical information necessary to process any claim and request payment of insurance benefits due to be paid to the Physician supplying the service.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient/Insured)

## Patient Clinical Information

Please indicate any of the following that pertain to your medical history.

<input type="checkbox"/> Kidney disorders	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Lung disorders
<input type="checkbox"/> Liver disorders	<input type="checkbox"/> Blood clots	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Tested positive HIV	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Stroke	<input type="checkbox"/> Ankle swelling
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Difficulty in healing
<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Pregnant

Do you have any disease, condition, or problem not listed above that you think we should know about?

Have you ever experienced any adverse side effects or ALLERGIES to:

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Novacaine	<input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> Cortisone
<input type="checkbox"/> Other antibiotics	<input type="checkbox"/> Tape	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Iodine
<input type="checkbox"/> Codeine	<input type="checkbox"/> Other pain medication	<input type="checkbox"/> Anti-inflammatory medication	

Other medication(s): \_\_\_\_\_

Name/Address Family Physician: \_\_\_\_\_

Presently under a physician's care?  Yes  No Reason: \_\_\_\_\_

Physician last seen Month: \_\_\_\_\_ Year: \_\_\_\_\_

Medications presently taking: \_\_\_\_\_

**In Emergency, contact:** (Other than spouse)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### Foot Health Information

What is your foot problem? \_\_\_\_\_

\_\_\_\_\_

When did it begin? \_\_\_\_\_

How have you treated your problem so far? \_\_\_\_\_

Have you seen another doctor for this problem? Yes No If so, who? \_\_\_\_\_

Have you ever seen a foot doctor before? Yes No If so, who? \_\_\_\_\_

Was this problem caused by an accident? Yes No If so, when? \_\_\_\_\_

Was this a work related injury? Yes No If so, where? \_\_\_\_\_

Shoe size: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_