PATIENT NAME: ____
FIRST MI LAST

HOME ADDRESS: ____________________________________ APARTMENT# __________

CITY: ______________ STATE: _______ ZIP: ________ DATE OF BIRTH: ___/___/___

SOCIAL SECURITY #: _____-_____-______ AGE: _____ SEX: ☐M ☐F NICKNAME: ____________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED
RACE: ☐ WHITE ☐ AFRICAN AMERICAN ☐ LATINO ☐ ASIAN ☐ OTHER ____________________
ETHNICITY: ☐ NOT HISPANIC ORIGIN ☐ HISPANIC ☐ OTHER

MAY WE LEAVE A MESSAGE?
HOME PHONE #: (_____) _____-________ YES NO
WORK PHONE #: (_____) _____-________ YES NO EMPLOYER: ____________________
CELL PHONE #: (_____) _____-________ YES NO OCCUPATION: ____________________
E-MAIL ADDRESS: ________________________ YES NO
SPOUSE NAME: ________________________ SPOUSE DOB: __________ CELL: (___) __________

*GUARANTOR: ________________________________ RELATIONSHIP TO PATIENT: __________
(PERSON RESPONSIBLE FOR BILLS) ☐ SELF

ADDRESS: ____ CITY: ____________________

STATE: __________ ZIP: _________ PHONE #: (____) _____-______ DATE OF BIRTH: ___/___/___

EMERGENCY CONTACT: ________________ RELATIONSHIP: __________ PHONE #: (____) _____-______
CELL PHONE# (_____)_____-______

PRIMARY CARE DOCTOR: ________________________________ CLINIC: ____________________

I WAS REFERRED TO THIS OFFICE BY: ☐ PHYSICIAN/NURSE ______________ ☐ FRIEND ______________
☐ HEALTH FAIR ☐ YELLOW PAGES/NEWSPAPER ☐ INTERNET ☐ OFFICE WEBSITE ☐ INSURANCE COMPANY

PHARMACY: __________________ LOCATION: __________________ PHONE #: (____) ____-_____

INSURANCE INFORMATION *** (WE WILL ALSO COPY YOUR CARDS UPON CHECK IN, PLEASE PROVIDE THE INSURED'S DATE OF BIRTH)*

PRIMARY INSURANCE COMPANY NAME: ____

ADDRESS: ______________ CITY/STATE: __________ ZIP: ______ PHONE #: (____) _____-______

INSURED NAME: ______________ INSURED'S DATE OF BIRTH __________ EMPLOYER ______________

ID # ________________ GROUP # __________ RELATIONSHIP TO SUBSCRIBER: ______________

SECONDARY INSURANCE COMPANY NAME: ____

ADDRESS: ______________ CITY/STATE: __________ ZIP: ______ PHONE #: (____) _____-______

INSURED NAME: ______________ INSURED'S DATE OF BIRTH __________ EMPLOYER ______________
ID # ________________ GROUP # __________ RELATIONSHIP TO SUBSCRIBER: ______________

I UNDERSTAND I HAVE BEEN PROVIDED; AND AGREE TO THE TERMS OF THE HIPAA PRIVACY POLICY AND FINANCIAL POLICIES. I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES RELATING TO MY FOOT & ANKLE CONDITION. I AUTHORIZE MY INSURANCE COMPANY TO BE BILLED AND PAY ASSOCIATED PODIATRISTS DIRECTLY FOR SERVICES RENDERED.

PATIENT SIGNATURE: ________________________________ **DATE:** ______________

IF A MINOR, PARENT OR GUARDIAN MUST SIGN

CURRENT FOOT PROBLEM:

PLEASE DESCRIBE YOUR FOOT PROBLEM:____________________

HOW LONG AGO DID THIS PROBLEM FIRST START? _________ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOPED 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 0 TO 10? (PLEASE CIRCLE)
(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 ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER ____________________

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? ____________________

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? ____________________

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? ____________________

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ NO OR ☐ YES (DESCRIBE) ____________________

____________________ IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

ALLERGIES: ☐ NONE KNOWN ☐ DRUG ALLERGIES____________________
☐ ANESTHESIA ____________________ ☐ ANTIBIOTICS ____________________
☐ TAPE ☐ LATEX ☐ IODINE ☐ NICKEL (METAL) ☐ FOODS/OTHER____________________

CURRENT MEDICATIONS:

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS) *****IF YOU HAVE A LIST, WE WILL COPY IT FOR YOU:**

NAME DOSE HOW OFTEN DO YOU TAKE?

____
____
____
____
____

☐ DO YOU TAKE BLOOD THINNERS? NAME OF MEDICATION:____________________

DO YOU USE INSULIN? ☐ YES OR ☐ NO

YOUR MEDICAL HISTORY: HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER TYPE:__________	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES TYPE: I OR II	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
EMPHESEMA	Y	N	NEUROLOGICAL DISORDER	Y	N	VASCULAR ISSUES	Y	N

LIST ANY OTHER PAST MEDICAL HISTORY:____________________

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

DO YOU HAVE ANY ARTIFICIAL JOINTS?

☐ KNEE ☐ HIP ☐ OTHER___________

DO YOU HAVE A HEART VALVE REPLACEMENT?

☐ YES ☐ NO

SOCIAL HISTORY

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE

☐ CURRENT USE - TYPE _________________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _________ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _________ TYPE ______________________

☐ CURRENT USE - TYPE ______________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

OCCUPATION: ____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐10% ☐25% ☐50% ☐75% ☐100%

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: ____

HEIGHT________ WEIGHT________ BLOOD PRESSURE__________ SHOE SIZE:_______ WIDTH:_______

FAMILY HISTORY

IS THERE A FAMILY HISTORY OF:

	MOTHER	FATHER	SISTER	BROTHER	MATERNAL GRANDMA	MATERNAL GRANDPA	PATERNAL GRANDMA	PATERNAL GRANDPA
DIABETES								
CANCER TYPE: ______________________								
HEART DISEASE								
HIGH BLOOD PRESSURE								
STROKE								
CORONARY ARTERY DISEASE								
THYROID DISEASE								
RHEUMATOID ARTHRITIS								

CONSENT:

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS. I REQUEST AND AUTHORIZE ASSOCIATED PODIATRISTS, LLP TO DIAGNOSE AND ADMINISTER TREATMENT FOR MY CONDITION.

PATIENT SIGNATURE:____DATE:____________________