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:_____