Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name _____ (Last Name / First Name / Initial) Soc. Sec.# _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐ M ☐ F Age _____ Birth Date _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient employed by _____ Occupation _____

Business Address _____

Business Phone _____ Business Email _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Whom may we thank for referring you? _____

Person Responsible for Account _____ (Last Name / First Name / Initial)

Relation to Patient _____ Birth Date _____ Soc. Sec.# _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible employed by _____ Occupation _____

Business Address _____

Business Phone _____ Business Email _____

Insurance Company _____

Phone _____ Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birth Date _____

Address (if different from patient) _____ City _____ State _____ Zip _____

Soc. Sec. # _____ Home Phone _____ Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____ Business Email _____

Insurance Company _____ Phone _____ Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.

Patient Podiatric and Health Information

Family Physician _____

Last Visit _____

What is the nature of your foot problem? _____

_____

Height _____ Weight _____ Shoe Size _____

Are you in good general health? ☐ Y ☐ N If no, explain _____

_____

Are your feet tired at the end of the day? ☐ Y ☐ N Do you have lower back pain? ☐ Y ☐ N

Have you ever broken a bone in your foot or ankle? ☐ Y ☐ N Have you had previous foot/ankle surgery? ☐ Y ☐ N

Do you use tobacco products? ☐ Y ☐ N If yes, what amount daily? _____

_____

Medical History

Check (✓) if you have had any of the following:

- ☐ Arthritis, Rheumatism
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Cramps/Numbness in feet or legs
- ☐ Diabetes
- ☐ Eye trouble
- ☐ Heart trouble
- ☐ High blood pressure
- ☐ Kidney trouble
- ☐ Liver trouble
- ☐ Swelling of feet or ankles
- ☐ Varicose veins

Are you allergic/sensitive to:

- ☐ Anesthetics
- ☐ Drugs
- ☐ Foods
- ☐ Materials
- ☐ Novocaine
- ☐ Penicillin
- ☐ Tape
- ☐ Other

List medications you are currently taking, if any:

_____ _____

_____ _____

_____ _____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.