

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Chart Number:** \_\_\_\_\_

**Sex:**  M  F **Marital Status:**  Single  Married  Widowed  Divorced **SS#** \_\_\_\_\_

**Spouse/Partner Name:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home #:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_ **Work #:** \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Date Last Seen:** \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ **Are you the insured?**  Yes  No

**Policy ID** \_\_\_\_\_ **Group ID:** \_\_\_\_\_

**Insured Information**

**Subscriber Name:** \_\_\_\_\_ **Relationship to insured:**  Spouse  Child  Self  Other

**Sex:**  Male  Female **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Phone #:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ **Are you the insured?**  Yes  No

**Policy ID** \_\_\_\_\_ **Group ID:** \_\_\_\_\_

**Insured Information**

**Subscriber Name:** \_\_\_\_\_ **Relationship to insured:**  Spouse  Child  Self  Other

**Sex:**  Male  Female **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Phone #:** \_\_\_\_\_

**How did you find out about our practice?**  Physician  Internet  Telephone Book  Family member  Friend

Other: \_\_\_\_\_

**What is the reason for your visit today?** \_\_\_\_\_

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**How long has this bothered you?** 1 2 3 4 5 6 7  days  weeks  months  years

**What treatments have you tried & have they been effective?** \_\_\_\_\_

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**On a scale of 1 - 10 ( 1 being no pain and 10 being the worst) what is your level of pain?** \_\_\_\_/10

**The pain quality is:**  burning  constant  dull  sharp  shooting  throbbing  tingling **Other:** \_\_\_\_\_

The above information is correct to the best of my knowledge, I understand that throughout my treatments, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

X \_\_\_\_\_ **Date:** \_\_\_\_\_

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

Date of birth: \_\_\_\_\_

Race: \_\_\_\_\_

I prefer not to answer     I do not know

(White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)

Ethnicity: \_\_\_\_\_

I prefer not to answer     I do not know

Preferred Language: \_\_\_\_\_

I prefer not to answer

**Privacy Information Preferences**

Did you receive a copy of the HIPAA Privacy Practice Notice:     Yes     No

Would you like your information to be confidential within our office and not included when the government requires us to file statistical reports on our patients?     Yes     No

Can we send mail to the address on file?     Yes     No

Can we call the phone number on file?     Yes     No

Can we leave voicemail on answering machine?     Yes     No

Will you allow internet based delivery reminders like email?     Yes     No

Who may we leave message with?     Wife     Husband     Daughter     Son

Other: \_\_\_\_\_

Height: \_\_\_\_\_    Weight: \_\_\_\_\_  
 I prefer not to answer     I do not know

**For Office Use Only**  
**Vital Signs**  
Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_

**Important:** If your insurance plan requires a paper referral, you must bring it with you. If it is a paperless referral, your primary care physician must call one in to the insurance company. An active referral must be present to be seen. **It is our policy to collect all copays and fees not covered by your insurance at the time of the visit. If you do not have insurance, full payment is expected. If required, payment plans may be arranged in advance of your visit by calling the billing office.**

**ASSIGNMENT AND RELEASE**

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X \_\_\_\_\_  
Responsible Party Signature

Relationship \_\_\_\_\_

Date \_\_\_\_\_

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. \_\_\_\_\_ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier.

Beneficiary Signature \_\_\_\_\_

Date \_\_\_\_\_

**CONSENT**

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and /or treatment of my feet.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Dr. Signature \_\_\_\_\_ Date \_\_\_\_\_

**History and Physical**

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Chart Number:** \_\_\_\_\_

**Medical History:**

<input type="checkbox"/> Asthma	<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Liver	<input type="checkbox"/> Skin disorders
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Blood clot	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Mental illness
<input type="checkbox"/> Allergies	<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Diabetes type 1	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Musculoskeletal
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Breathing issues	<input type="checkbox"/> Diabetes type 2	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Neurological
<input type="checkbox"/> Arthritis (specify) _____	<input type="checkbox"/> Gout	<input type="checkbox"/> Kidney	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Other (specify) _____				

**Are you pregnant?**  Yes  No      **Are you nursing?**  Yes  No

**Surgical History**  Yes  No  
 Have you ever had any surgical procedures on foot/ankle or anywhere else on your body?  
 If yes, please describe: \_\_\_\_\_  
 Do you have any artificial joints?  Yes (where? \_\_\_\_\_)  No      Do you have an artificial heart valve?  Yes  No

**Social History**

Do you smoke?  Yes  No    If yes how many packs per day? \_\_\_\_\_ For how long? \_\_\_\_\_  Former smoker  
 Do you drink alcohol?  Yes, everyday (5-7days/week)  Yes, occasionally/socially  No/Rarely  
 Substance abuse:  Yes, I have a current substance abuse problem. Please specify: \_\_\_\_\_  
 Yes, I had a past substance abuse problem. Please specify: \_\_\_\_\_  
 No, I have never had a substance abuse problem  
 What is your occupation? \_\_\_\_\_ Does it involve mostly  standing or  sitting  
 Do you exercise regularly?  Yes, I do the following regular exercise: \_\_\_\_\_  
 No, I do not exercise regularly

**Family History** Is there any family history (blood relative) of: (Please indicate family member)

<input type="checkbox"/> Arthritis Type	<input type="checkbox"/> Cancer Type	<input type="checkbox"/> Flatfeet	<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Hammer toes
<input type="checkbox"/> Blood clot/DVT/PE	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Bunions	<input type="checkbox"/> Neurological	<input type="checkbox"/> Strokes
<input type="checkbox"/> Other (specify): _____					

**Current Medications**  None  I take the following Prescription or over the counter medications:

Name: _____	Dose _____	How often? _____
Name: _____	Dose _____	How often? _____
Name: _____	Dose _____	How often? _____
Name: _____	Dose _____	How often? _____
Name: _____	Dose _____	How often? _____
Name: _____	Dose _____	How often? _____
Name: _____	Dose _____	How often? _____

Use the back of this form if more room is needed

**Allergy**  No Known Allergies      **Reaction**

<input type="checkbox"/> Penicillin	_____
<input type="checkbox"/> Shellfish	_____
<input type="checkbox"/> Sulfa	_____
<input type="checkbox"/> Tape	_____
<input type="checkbox"/> Latex	_____
<input type="checkbox"/> Betadine (iodine)	_____
<input type="checkbox"/> Aspirin	_____
<input type="checkbox"/> Tylenol™	_____
<input type="checkbox"/> Ibuprofen	_____
<input type="checkbox"/> Codeine	_____
<input type="checkbox"/> Other (specify) _____	_____

**Review of Systems** (Please check the box if you currently have any of these symptoms)

<b>Cardiovascular</b>	<input type="checkbox"/> leg pain when walking	<input type="checkbox"/> nausea	<input type="checkbox"/> fever	<input type="checkbox"/> chest pain	<input type="checkbox"/> chest pressure/angina
	<input type="checkbox"/> vomiting	<input type="checkbox"/> chills	<input type="checkbox"/> leg swelling	<input type="checkbox"/> cold hands/feet	<input type="checkbox"/> weight gain/weight loss
	<input type="checkbox"/> leg cramps	<input type="checkbox"/> high blood pressure/hypertension	<input type="checkbox"/> varicose veins		
<b>Genitourinary</b>	<input type="checkbox"/> blood in urine	<input type="checkbox"/> hesitancy	<input type="checkbox"/> incontinence	<input type="checkbox"/> decreased frequency	
<b>Gastrointestinal</b>	<input type="checkbox"/> currently pregnant	<input type="checkbox"/> excessive urination	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> heartburn	
<input type="checkbox"/> kidney disease	<input type="checkbox"/> kidney stones	<input type="checkbox"/> blood in stool	<input type="checkbox"/> vomiting	<input type="checkbox"/> ulcers	
<input type="checkbox"/> diarrhea	<input type="checkbox"/> indigestion				
<b>Integumentary</b>	<input type="checkbox"/> athletes foot	<input type="checkbox"/> nail abnormalities	<input type="checkbox"/> keloids	<input type="checkbox"/> itchiness	<input type="checkbox"/> dry, scaly skin
<b>Hematologic</b>	<input type="checkbox"/> lower leg ulcers	<input type="checkbox"/> sickle cell disease	<input type="checkbox"/> clotting disorders	<input type="checkbox"/> rash	<input type="checkbox"/> anemia
	<input type="checkbox"/> bleeding problems	<input type="checkbox"/> use of blood thinners			
<b>Neurological</b>	<input type="checkbox"/> tingling	<input type="checkbox"/> weakness	<input type="checkbox"/> seizures	<input type="checkbox"/> numbness	
<b>Musculoskeletal</b>	<input type="checkbox"/> back pain	<input type="checkbox"/> joint swelling	<input type="checkbox"/> tremors	<input type="checkbox"/> paralysis	<input type="checkbox"/> muscle weakness
<input type="checkbox"/> muscle pain	<input type="checkbox"/> neck pain	<input type="checkbox"/> sciatica	<input type="checkbox"/> joint stiffness	<input type="checkbox"/> joint pain	<input type="checkbox"/> joint instability
<b>Respiratory</b>	<input type="checkbox"/> chest pain	<input type="checkbox"/> difficulty breathing	<input type="checkbox"/> arthritis	<input type="checkbox"/> wheezing	
	<input type="checkbox"/> coughing	<input type="checkbox"/> snoring	<input type="checkbox"/> shortness of breath		