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? _____

_____

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? _____

_____

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:

☐ Alcoholism	☐ Asthma	☐ Circulation problems	☐ Heart Disease	☐ Liver	☐ Skin disorders
☐ Allergies	☐ Blood clot	☐ Depression	☐ Heart murmur	☐ Mental illness	☐ Sleep apnea
☐ Anxiety	☐ Blood disorders	☐ Diabetes type 1	☐ High blood pressure	☐ Musculoskeletal	☐ Stomach/bowel
☐ Arthritis *(specify)*_____	☐ Breathing issues	☐ Diabetes type 2	☐ High Cholesterol	☐ Neurological	☐ Stroke
☐ Other *(specify)* _____		☐ Gout	☐ Kidney	☐ Osteoporosis	☐ Thyroid

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*)

☐ Arthritis Type	☐ Cancer Type	☐ Flatfeet	☐ Bleeding disorders	☐ Circulation problems	☐ Hammer toes
☐ Blood clot/DVT/PE	☐ Diabetes	☐ Heart disease	☐ Bunions	☐ Neurological	☐ Strokes

☐ 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?_____

Name: _____ Dose _____ How often?_____

Use the back of this form if more room is needed

Allergy ☐ No Known Allergies	**Reaction**
☐ Penicillin	_____
☐ Shellfish	_____
☐ Sulfa	_____
☐ Tape	_____
☐ Latex	_____
☐ Betadine (*iodine*)	_____
☐ Aspirin	_____
☐ Tylenol ™	_____
☐ Ibuprofen	_____
☐ Codeine	_____
☐ Other (*specify*) _____	_____

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

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