NEW PATIENT INFORMATION

(PLEASE PRINT; ALL INFORMATION IS STRICTLY CONFIDENTIAL)

Patient Name: ______________________________ ________________________ ________ Age: _______
(Last) (First) (MI)

Date of Birth: _____/_____/_____ Gender: Male Female Social Security No: _________________________

Home Address: ____
Street Address City State Zip

Home Phone: (_____)__________ -- ____________ Cell Phone: (______)__________ -- ____________

Work Phone: (_____)__________ -- ____________ E-mail: _____________________________

Preferred Contact Method: ☐ Home ☐ Cell ☐ Work ☐ E-Mail

Preferred Language: ☐ English ☐ Spanish ☐ Other ________________ ☐ Decline to Specify

Race: ☐ White ☐ African American ☐ Hispanic/Latino ☐ Other __________ ☐ Decline to Specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

Primary Care Doctor: ______________________________ Referring Doctor: ___________________________

Preferred Pharmacy: ____
Name City/State Phone

RESPONSIBLE PARTY / INSURANCE INFORMATION

	Name/Relationship	Phone Number
Legal Guardian/Power of Attorney	______________________________	________________
Emergency Contact	______________________________	________________
Individuals to Share Medical Info.	______________________________	________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Partnered
Spouse/Partner Name: ______________________________

Person Responsible for Payment:

☐ Self Other: Name: ____________________________ Relationship: __________ DOB:____/____/____

Address: ____
Street Address City State Zip

Primary Insurance Company Name: __________________________________ Phone: ____________________

Name of person who carries insurance _________________________________ DOB: ____/____/_____

Secondary Insurance Company Name: ________________________________ Phone: ____________________

Name of person who carries insurance _________________________________ DOB: ____/____/_____

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MEDICAL INFORMATION

Height: _______________ Weight: _______________ Shoe Size: _______________

REVIEW OF SYSTEMS: Are you experiencing any of the following? Please check all that apply.

Constitutional:
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Body Ache
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

Head:
- ☐ Vision Change
- ☐ Headache
- ☐ Hearing Change
- ☐ Nasal Congestion

Hematologic:
- ☐ Slow Healing
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Blood Clots
- ☐ Swollen Glands

Additional:

____

____

Respiratory:
- ☐ Cough
- ☐ Shortness of Breath
- ☐ TB Exposure
- ☐ Wheezing

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Gallbladder Disease
- ☐ Appetite Loss
- ☐ Nausea
- ☐ Vomiting
- ☐ Liver Disease

Neurological:
- ☐ Unsteady Walking
- ☐ Dizziness
- ☐ Burning
- ☐ Numbness
- ☐ Tingling

Cardiovascular:
- ☐ Chest Pain
- ☐ Chest Pressure
- ☐ Varicose Veins
- ☐ Irregular Heartbeat
- ☐ Leg Hair Loss
- ☐ Ulcer Leg/Foot
- ☐ Swelling of Leg/Foot
- ☐ Leg Cramping
- ☐ Difficulty Breathing While Lying Flat
- ☐ Murmur
- ☐ Cold Extremities

Dermatological:
- ☐ Itchy Skin
- ☐ Rash
- ☐ Skin Infection
- ☐ Dry Skin
- ☐ Sweaty Skin
- ☐ Skin Lesion
- ☐ Wart
- ☐ Athlete's Foot
- ☐ Ingrown Nail
- ☐ Nail Changes

Genitourinary:
- ☐ Frequent Urination
- ☐ Incontinence
- ☐ STD
- ☐ Urinary Tract Infection

Musculoskeletal:
- ☐ Arthritis
- ☐ Low Back Pain
- ☐ Joint Stiffness
- ☐ Weakness
- ☐ Paralysis
- ☐ Fracture
- ☐ Gout
- ☐ High Arch
- ☐ Flat Foot (Low)
- ☐ Bunion
- ☐ Hammer Toe
- ☐ Orthotic Use
- ☐ Implant
- ☐ Rheumatologic condition
- ☐ Altered Walking Style
- ☐ Joint Pain: __________ ____________________

MEDICATIONS: List all you are taking including prescriptions, over-the-counter, herbal supplements.

Medication Name	Dose	How Often?
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________

***Please include additional list if needed*

ALLERGIES: List all including medications, anesthesia, food, tape, latex, iodine, or other

Allergen	Describe Reaction
______________________	____
______________________	____
______________________	____

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SURGERIES AND HOSPITALIZATIONS:

Surgery/ Hospitalization	Approximate Date	Reason

SOCIAL HISTORY:

	Never	Use History/Amount/Details
Alcohol	☐	
Tobacco (Packs/Day & Yrs)	☐	
Recreational Drugs	☐	
Caffeine	☐	
Exercise	☐	

PERSONAL AND FAMILY MEDICAL HISTORY:

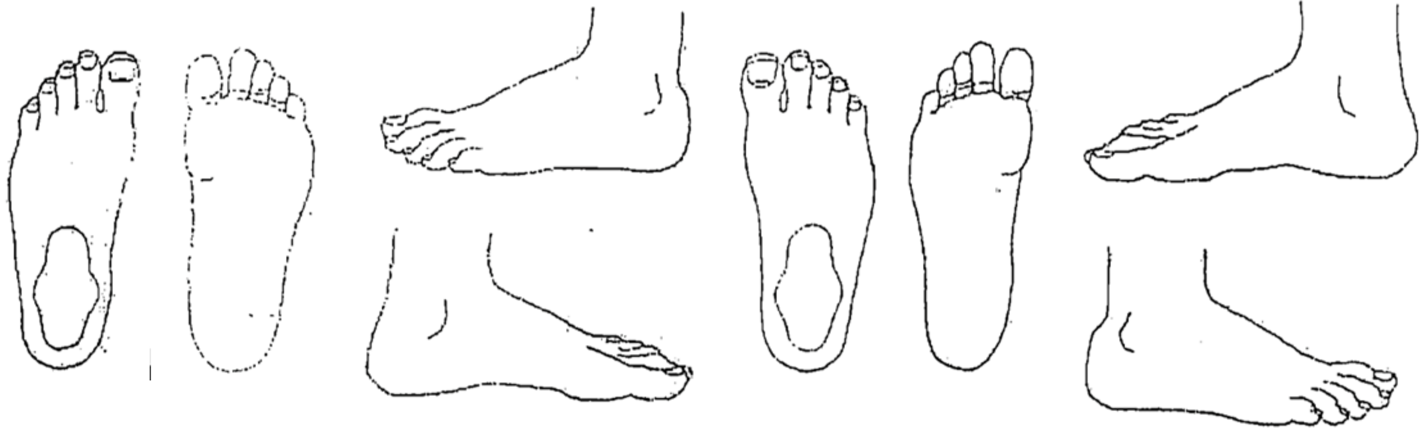
	You	Father	Mother	Sibling	Children	Other
Arthritis	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐
Circulation problems	☐	☐	☐	☐	☐	☐
Blood clots / DVT	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Deceased (age)		☐	☐	☐	☐	☐

Please list any other medical problems not listed above: ______________________________

What is your foot/ankle problem? ______________________________

Where is your pain/problem located? (Please mark)

Left Foot | Right Foot



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How long ago did this problem first start? _____________ Was it: ☐ Gradual ☐ Sudden

Describe your pain: ☐ No Pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning
☐ Radiating ☐ Itching ☐ Stabbing ☐ Other: ___________________

What aggravates your condition? ________________________ What provides relief? ____________________________

Rate your pain (please circle): *(No Pain)* 0 1 2 3 4 5 6 7 8 9 10 *(Worst Pain Possible)*

What treatments have you tried? ____

Employer Name: ________________ Percentage of time on feet at work: ______ Do others depend on your care? ____

ACKNOWLEDGEMENT, CONSENT, AND ASSIGNMENT OF BENEFITS

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 it is my responsibility to inform the doctor and office staff of any changes in my medical status. I hereby give my consent for administration and performing such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and/or ankles.

I certify that I (or my dependent) have coverage with my insurance company as presented and I assign directly to the Foot & Ankle Center all insurance benefits, payable to me for services rendered. I understand I am responsible for payment of deductibles, co-payments, co-insurance, non-covered services and other fees at the time of service. I authorize the Foot & Ankle Center to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I understand it is my responsibility to inform the Foot & Ankle Center if there is a change in my health insurance information.

I consent to the release of medical records to entities providing financial reimbursement of charges incurred during the course of treatment. This may include, but is not limited to, insurance companies, self-insured employers, or public welfare agencies. I understand that records of a confidential nature, such as those for HIV testing, AIDS or AIDS related condition, psychiatric problems, or substance abuse will be released to the entities providing financial assistance for my health care. I hereby consent to the release of medical records prepared in the course of my treatment to any entity including, but not limited to, referring physicians, hospitals, or other medical providers to maintain continuity of care. I acknowledge that I have read or was given the opportunity to read a copy of the Notice of Privacy Practices and the Patient Financial Policy. The signature provided on this form shall suffice for all insurance forms on a continuing basis.

Name: ____ Date: _________________________________
Printed Name or Parent/Guardian if under 18

Signature: ____