DATE ___________________

NAME____DOB__________AGE____SHOE SIZE____

HOME PHONE ________________________________ CELL PHONE________________________________

PHARMACY AND PHONE____

PRIMARY CARE DR AND PHONE____

MEDICATIONS CURRENTLY TAKING____

____

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 ______________________ Soc. Sec.# ______________
Last Name First Name Initial

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? ______________________

Primary Insurance

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 you 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.

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