

## Patient Information

Date		Last Name		First Name		MI	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Home Phone		Cell Phone		E-mail Address					
Street		City		State		Zip Code			
Social Security #		Driver's License #		Age	Date of Birth	Marital Status		# of Children	Children's Ages
Employer				Phone Number		Ext.			
Street		City		State		Zip Code			
Occupation				May we call you at work?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Work Hours	
Emergency Contact		Relationship		Phone Number					

## Spouse/Domestic Partner Information (If appropriate)

Last Name		First Name		MI	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Age	Date of Birth
Home Phone		Cell Phone		Social Security #		Driver's License #		
Street		City		State		Zip Code		
Employer				Phone Number		Ext.		
Street		City		State		Zip Code		

## Financially Responsible Party (If different from patient)

Last Name		First Name		MI	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Age	Date of Birth	
Home Phone		Social Security #		Driver's License #		Marital Status		# of Children	Children's Ages
Street		City		State		Zip Code			
Employer				Phone Number		Ext.			
Street		City		State		Zip Code			
Occupation				May we call you at work?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Work Hours	

## Insurance Information (Please bring insurance card to each appointment)

Primary Insurance		Phone Number		Group #			
Street		City		State		Zip Code	
Insured's Name		Insured's ID #		Copay \$ (required at each visit)			
Primary Insurance		Phone Number		Group #			
Street		City		State		Zip Code	
Insured's Name		Insured's ID #		Copay \$ (required at each visit)			

Who may we thank for referring you?

First & Last Name

Phone Number

**Please read and sign below:** I directly assign all medical and surgical benefits to the doctor. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that fees for service and insurance copays are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co-insurance.

*It is the policy of this office to bill your insurance for reimbursement. However, we shall allow no more than sixty (60) days for payment. After sixty (60) days you will be billed for any outstanding balance on your account. All outstanding balances are due thirty (30) days from the statement date.*

I HEREBY GIVE AUTHORIZATION FOR TREATMENT.

Signature

Date

## Patient Foot/Ankle History

Describe your foot/ankle problem:

When did the problem begin? (date)

Describe any accident/event

Is this problem work related?  Yes  No

Please bring all imaging films to your first appointment.

Date taken?

Yes  No Previous X-rays?

Yes  No Previous MRI?

Yes  No Previous CT?

Yes  No Previous Labs?

Yes  No Previous Surgery?

Surgery type

Previous Physician

Phone Number

## Do you have, or have you been treated for:

- |  |  |  |  |   |
|--|--|--|--|---|
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Callouses               | <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Intoeing              | <input type="checkbox"/> Psychiatric / Psychological care |
| <input type="checkbox"/> Ankle injury        | <input type="checkbox"/> Childhood foot problems | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Kidney trouble        | <input type="checkbox"/> Rash                             |
| <input type="checkbox"/> Arch pain           | <input type="checkbox"/> Corns                   | <input type="checkbox"/> Heart murmur        | <input type="checkbox"/> Knee pain             | <input type="checkbox"/> Reflux / Heartburn               |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Heel pain           | <input type="checkbox"/> Liver disease         | <input type="checkbox"/> Rheumatism                       |
| <input type="checkbox"/> Artificial joints   | <input type="checkbox"/> Fibromyalgia            | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Lower back pain       | <input type="checkbox"/> Sleep apnea*                     |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Flat feet               | <input type="checkbox"/> High arch feet      | <input type="checkbox"/> Motion sickness       | <input type="checkbox"/> Stroke                           |
| <input type="checkbox"/> Blood disease       | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Neurological disorder | <input type="checkbox"/> Ulcers                           |
| <input type="checkbox"/> Broken foot bone(s) | <input type="checkbox"/> Hammertoes              | <input type="checkbox"/> HIV                 | <input type="checkbox"/> Neuroma               |   |
| <input type="checkbox"/> Bunions             |  | <input type="checkbox"/> Ingrown nails       | <input type="checkbox"/> Phlebitis             |   |

If "yes" to any above, please explain:

## Patient Medical History Overview

Height

Weight

Shoe Size

How much are your feet at work?  20%  40%  60%  80%  100%

List all allergies:

List all medications you are currently taking:

Are you taking any nutritional or dietary supplements?  Yes  No

(e.g. Ginkgo biloba, Ginseng, Echinacea)

List

Do you smoke?  Yes  No

Pack/Day

Years

Did you ever smoke?  Yes  No

Pack/Day

Years

When did you quit?

Do you use "recreational drugs"?  None  Rarely  Moderately  Daily  Quit

Do you drink alcoholic beverages?  None  Rarely  Moderately  Daily  Quit

List

List any sports/activities you participate in:

Yes  No Do you use a CPAP machine? \*

Yes  No Are you slow to heal after cuts?

Yes  No Any abnormal bruising or bleeding?

Yes  No Any pain in calves or buttocks when walking?

Yes  No Is the pain relieved by rest?

Yes  No Do your feet hurt at night?

Yes  No Have you had a serious illness?

Yes  No Have you been hospitalized or under

Yes  No lengthy medical care?

Yes  No Do you have any implants?

Yes  No Cardiac (e.g. valve, pacemaker, graft, etc.)

Yes  No Cosmetic (e.g. breast, facial, etc.)

Yes  No Orthopedic (e.g. knee, hip, etc.)

If "yes" to any, please explain:

## Patient Physicians

Did your Family Physician or other Specialist refer you?  Yes  No

Family Physician name:

Specialist Name:

Specialty

Family Physician Name:

Date last seen

Phone Number

City

State

Zip

Specialist Name:

Date last seen

Phone Number

City

State

Zip

Did you come here for a:  Consultation  Surgical Evaluation  Second Opinion on Surgery  Independently for an Opinion

## Family History

Has any blood relative had any of the following? (If "Yes" please indicate who)

Yes  No Arthritis

Yes  No Birth Abnormalities

Yes  No Cancer or Tumor

Yes  No Diabetes

Yes  No Foot Problems

Yes  No Heart Trouble

Yes  No High Blood Pressure

Yes  No Stroke

Yes  No Tuberculosis