

Patient Information Form

(Please Print)

Date: ____ / ____ / ____

Patient Information

Patient Name: _____ Date of Birth: ____ / ____ / ____ Sex: M F
Last First

Home Address: _____ City: _____ State: _____ Zip: _____

SSN #: _____ - _____ - _____ Home #: (____) _____ - _____ Cell #: (____) _____ - _____

Work #: (____) _____ - _____ Ext #: _____ E-Mail: _____

Primary Language: _____ Race/Ethnicity: _____
 Prefer not to report

Marital Status: Single Married Separated Divorced Widowed

Employer: _____ Occupation: _____

Do you have a legal guardian or healthcare power of attorney? Yes No

If Yes, Name: _____ Relationship: _____ Phone #: (____) _____ - _____

Emergency Contact: _____ Relationship: _____ Phone #: (____) _____ - _____

Primary Care Doctor: _____ Who referred you to us? _____

Pharmacy: _____ Location: _____ Phone #: (____) _____ - _____

Is there a family member or other person you would like for us to share your medical information?

Yes Name(s) _____
 No

Insurance Information

Company: _____

Insured's Name: _____ Insured's Date Of Birth: ____ / ____ / ____

Insured's SSN #: _____ - _____ - _____

Current Problem

What specific problem brings you to our office today? _____

How long ago did this problem first start? _____ Days / Weeks / Months / Years

How would you describe your pain? No Pain Sharp Dull Aching Burning Radiating

Itching Stabbing Other: _____

How would you rate your pain on a scale from 0 to 10? (Please circle)

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain possible)

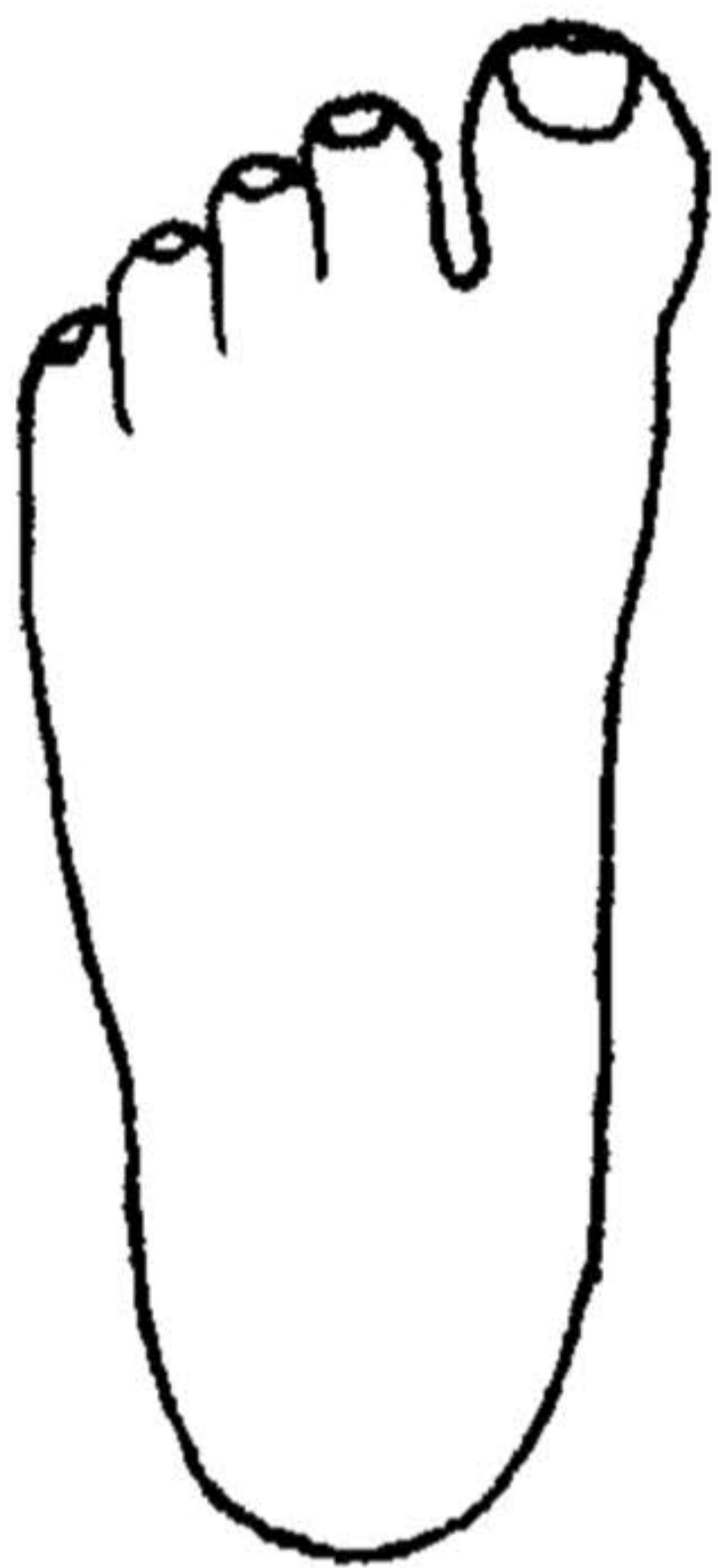
What treatments have you had for this problem? _____

Was this problem cause by an injury? Yes (describe) _____
 No

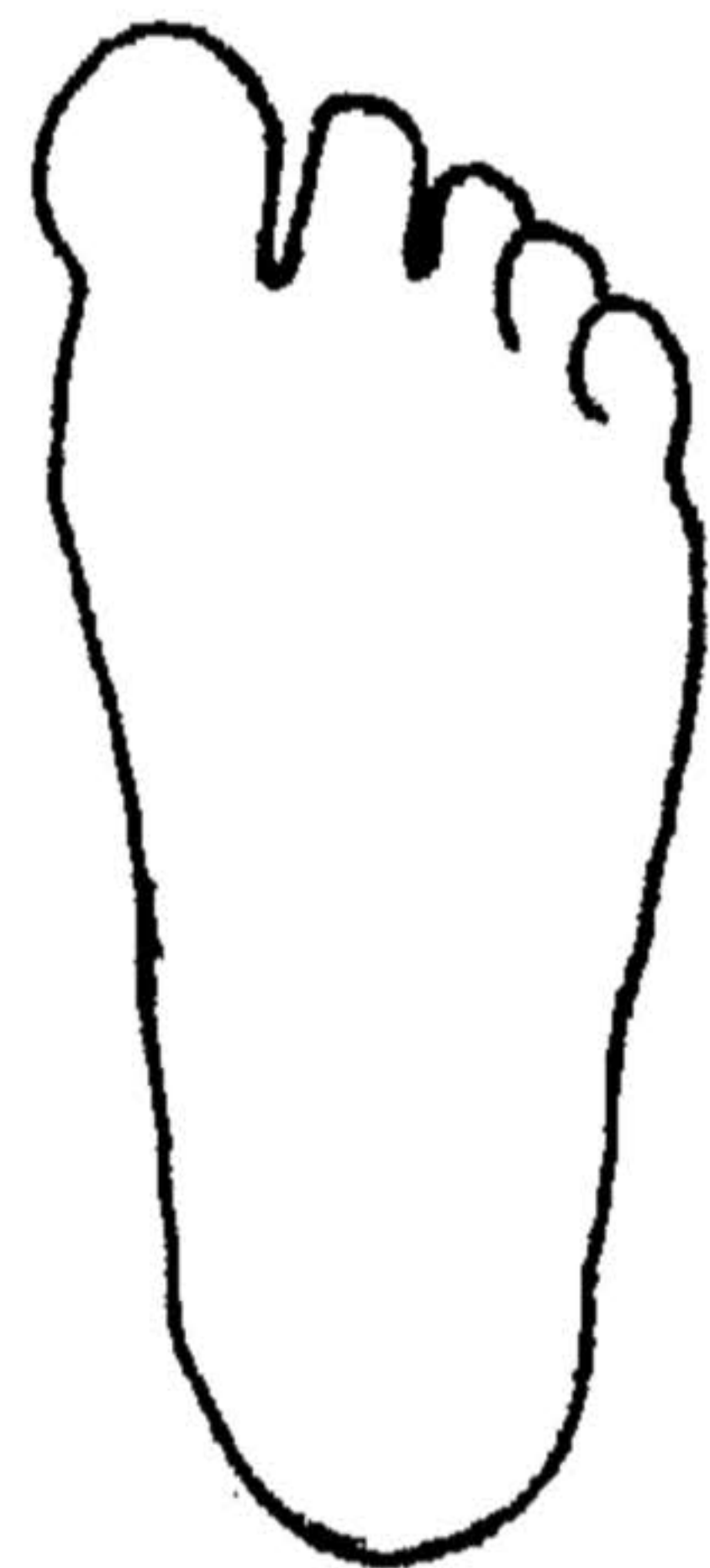
If Yes, was this a work related injury? Yes
 No

Where is the pain / problem located? Please mark on the pictures below:

LEFT FOOT



TOP OF FOOT



BOTTOM OF FOOT

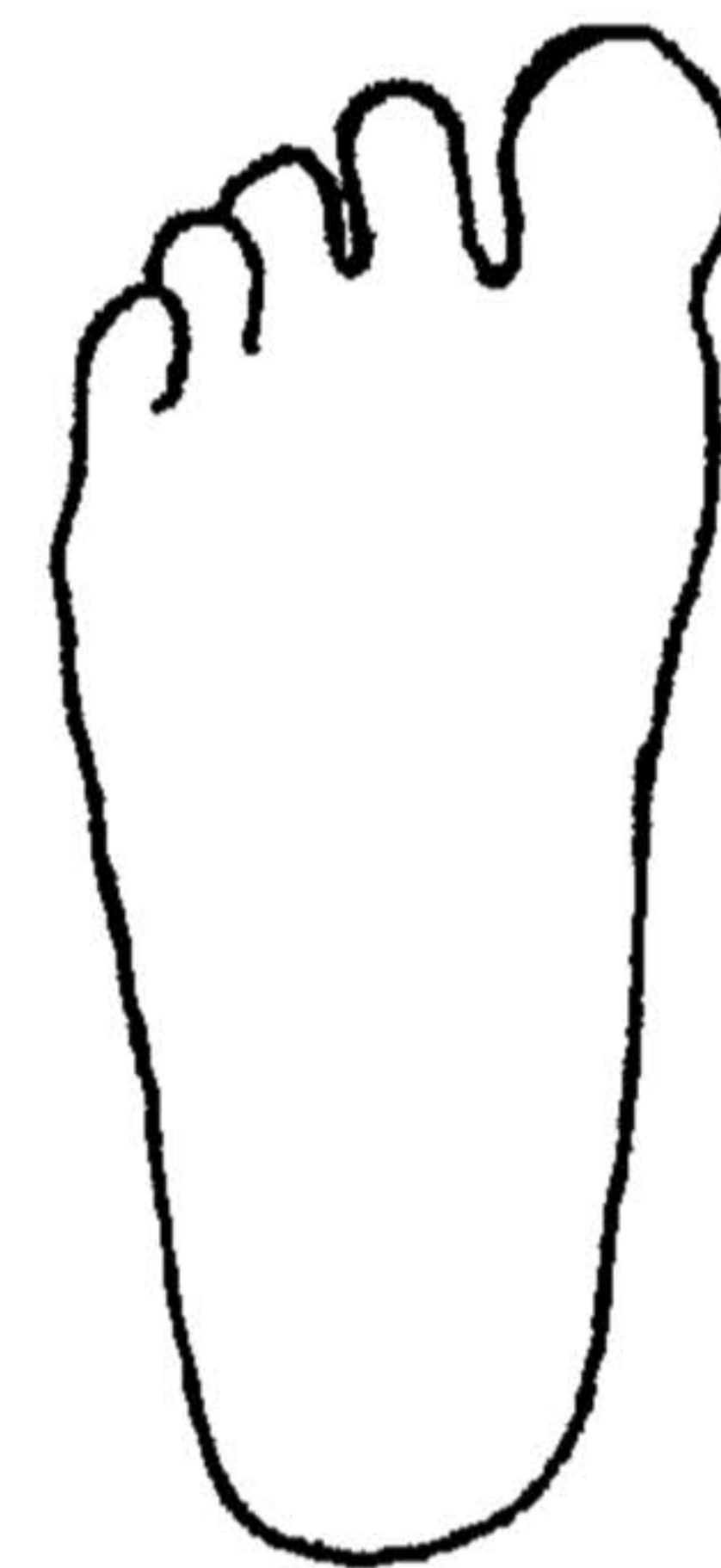


INSIDE OF FOOT

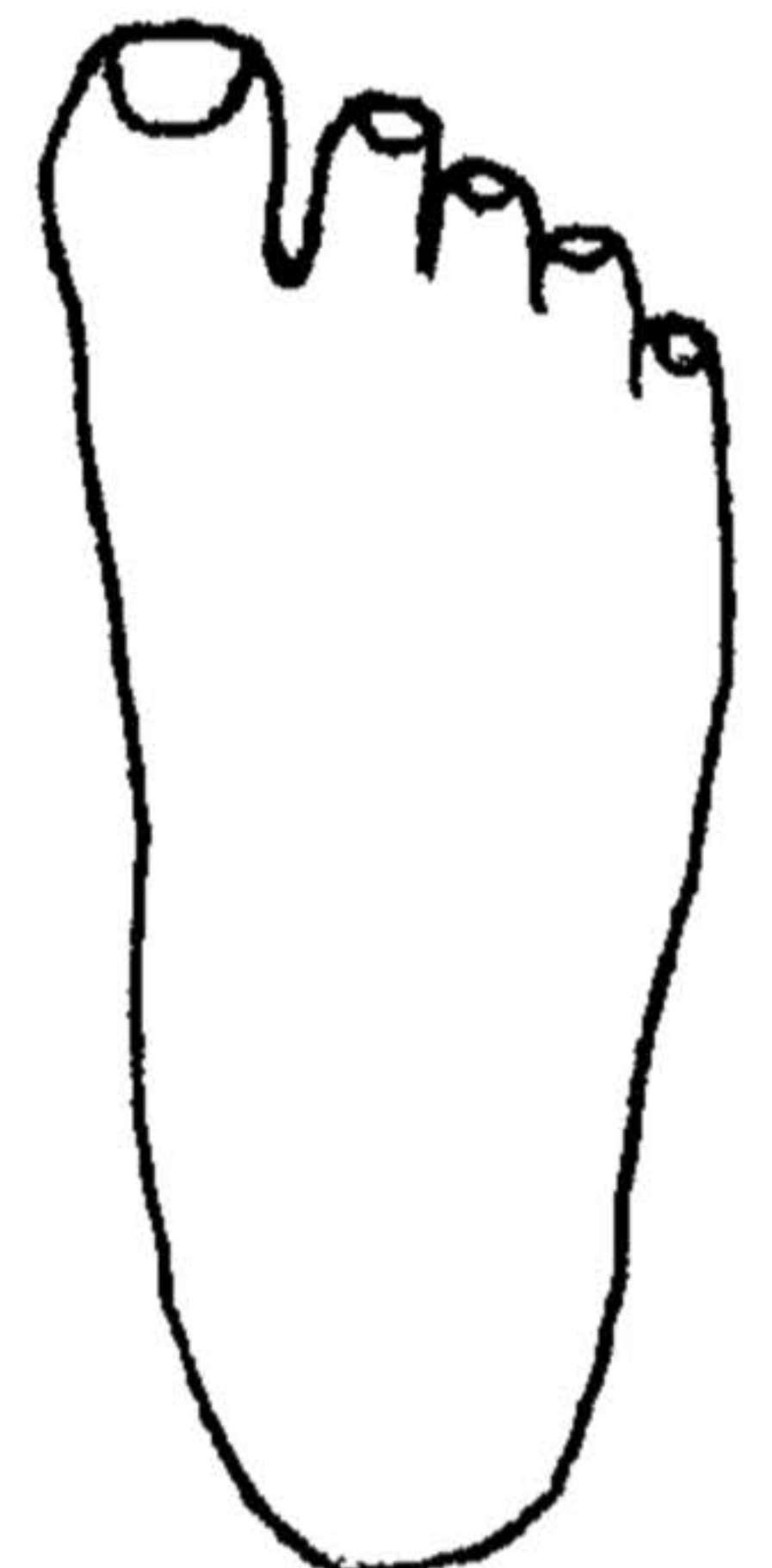


OUTSIDE OF FOOT

RIGHT FOOT



BOTTOM OF FOOT



TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

Medical History

Allergies: None Known Medications: _____
 Anesthesia Tape Latex Shellfish Iodine Food Other _____

Have you ever had any of the following?

Acid Reflux	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Open Sores	Y	N
Arthritis	Y	N	Heart Attack	Y	N	Pneumonia	Y	N
Asthma	Y	N	Heart Disease/Failure	Y	N	Polio	Y	N
Back Trouble	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Bladder Infections	Y	N	HIV+/AIDS	Y	N	Sickle Cell Disorder	Y	N
Abnormal Bleeding	Y	N	High Blood Pressure	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	Kidney Disease	Y	N	Sleep Apnea	Y	N
Blood Transfusion	Y	N	Liver Disease	Y	N	Stomach Ulcers	Y	N
Bronchitis/Emphysema	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Cancer	Y	N	Migraine Headaches	Y	N	Thyroid Disease	Y	N
Diabetes	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N

Height: _____ Weight: _____ Shoe Size: _____

Please List all prior Surgeries:

Type of Surgery	Date	Type of Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all prior hospitalizations (Other than for Surgery)

Reason for hospitalization	Date	Reason for hospitalization	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all medications you are currently taking:

Name	Dose	How often do you take them?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Do you have a family history of: Diabetes Cancer Heart Disease High Blood Pressure
 Stroke Coronary Artery Disease Thyroid Disease Arthritis Other: _____

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 that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Print name of patient, Parent/Guardian

If other than patient, relationship to patient

Signature

Date

Authorizations

Benefits to Physician:

Yes No I hereby authorize payment directly to the physician of the surgical and/or medical benefits.

Yes No I also understand I am responsible for any portion of my bill not covered by my insurance company.

Release of Information:

Yes No The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS.

Date: ____ / ____ / _____ Signature: _____ Guardian: _____

Acknowledgement of receipt of notice of Privacy Practices:

I acknowledge that I was provided a copy of the Notice of Privacy Practices and I have read (or had the opportunity to read if I so chose) and understand the notice.

Date: ____ / ____ / _____ Signature: _____ Guardian: _____