NEXT STEP
FOOT & ANKLE CLINIC
Where will your feet take you?

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**www.nextstepfoot.com**

# Welcome to our practice!

We are happy you chose us for your foot care needs.

First, please take a moment to complete your **New Patient Intake forms**.

You will then be prompted to read through and sign our **Financial & Privacy Policy Agreement.**

In order to ensure a speedy intake process, please complete and submit **before your scheduled appointment date.**

Thank you for taking the Next Step with,

**Next Step Foot & Ankle Clinic & Surgery**
**Darren Silvester, DPM, ACFAS, ABFAS**
**Boyd Bills, DPM**
**Gregory Larsen, DPM**

## 1. YOUR INFORMATION

Last Name: _____ Legal First Name: _____ Middle Name: _____

DOB: _____ Age: _____ Shoe Size: _____ Gender: ○ Male ○ Female Weight: _____ Height: _____

Address: _____ Apt #: _____ City: _____

State _____ Zip: _____ Email: _____ Phone: _____

How did you hear about our office? _____ If other: _____

Reason for your visit with us? Date occured:

## 2. EMERGENCY CONTACT INFORMATION

Name: Relationship: Contact Number:

PCP or Referring Physician (Full Name): Where are they located? Contact Number:

If Diabetic, Full Name of Diabetic Dr: Where are they located? Contact Number: When did you see them last?

A1C Score:

## 3. INSURANCE INFORMATION

Do you have insurance?
○ Yes ○ No

Are you the:
○ Primary Insured ○ Dependent

Does the card say:
○ HMO ○ PPO ○ EPO

Is your injury/condition: If other: Does it require a referral?
○ Yes ○ No

Insurance Carrier: Name on Insurance Card:

If TRICARE:

Sponsor Name: Sponsor DOB: Sponsor Social

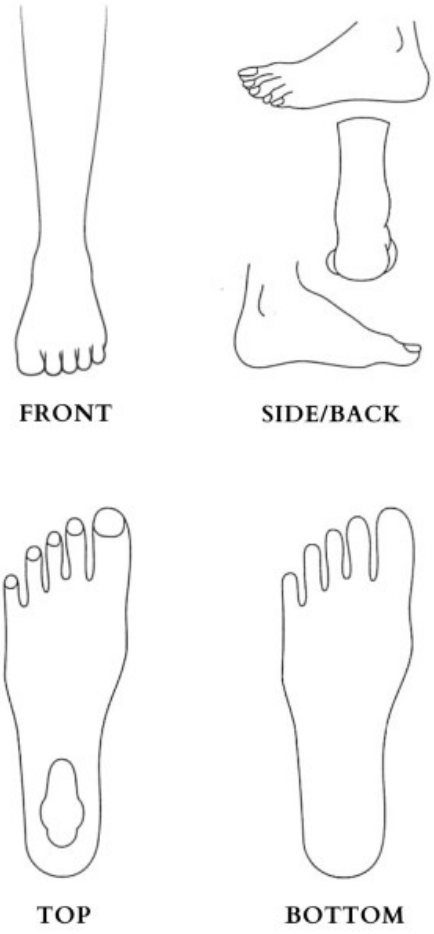
## 4. INSURANCE CARD Please attach your Insurance Card. (Front & Back) If you are filling this out via SMS, you can use your camera to take a picture and upload the FRONT & BACK of your card.

## 5. CURRENT PROBLEMS Circle area(s) where the pain is in your LEFT FOOT: To indicate the pain level, change the color of the brush by selecting: Red - SEVERE | Green - MODERATE | Blue - MILD MOBILE USERS: Slide your finger upwards on the far left side of the image to scroll up.

0 - Severe 1 - Moderate 2 - Mild

# Left Foot

PAIN DIAGRAM




6. LEFT FOOT ISSUES

Pain Scale (1-10 | 10 being the worst):

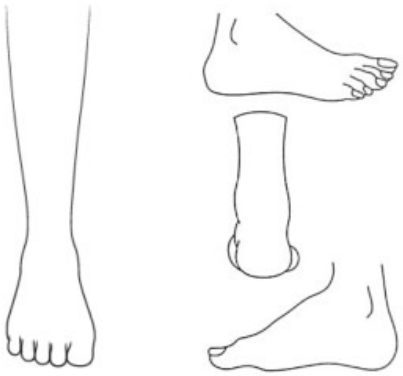
_____

7. CURRENT PROBLEMS Circle area(s) where the pain is in your RIGHT FOOT: To indicate the pain level, change the color of the brush by selecting: Red - SEVERE | Green - MODERATE | Blue - MILD MOBILE USERS: Slide your finger upwards on the far left side of the image to scroll up.

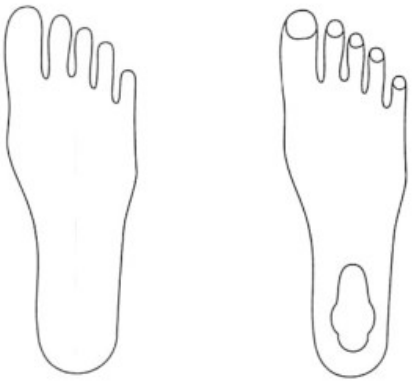
0 - Severe 1 - Moderate 2 - Mild

# Right Foot

PAIN DIAGRAM



FRONT SIDE/BACK



BOTTOM TOP

## 8. RIGHT FOOT ISSUES

Pain Scale (1-10 | 10 being the worst):

_____

## 9. OTHER CONCERNS (Please check all that apply)

☐ Falling _____

☐ Poor Circulation _____

☐ Fungus _____

☐ Replace Orthotics _____

☐ Ingrown Toenail _____

☐ Other: _____

## 10. PAST MEDICAL HISTORY (Please check all that apply)

☐ None

☐ Anesthetic Complications

☐ Hypertension/High Blood Pressure

☐ Heart Disease
☐ Hepatits/Liver Disease
☐ Kidney Disease/UTI
☐ Lung Disease
☐ HIV
☐ Diabetes
☐ Thyroid Disfunction
☐ Varicosities/Phlebitis
☐ Peripheral Vascular Disease
☐ Depression
☐ Swelling of:
☐ Other:

## 11. VACCINATIONS

| Type: | FLU | PNEUMONIA | TETANUS |
|---|---|---|---|
| Date Received: | | | |

## 12. PREVIOUS PROCEDURES OR SURGERIES (Please check all that apply)

☐ None
☐ Foot or Ankle Surgery
☐ Lower Extremity Vascular Surgery
☐ Lower Extremity Bypass
☐ Lower Extremity Stent
☐ Hip Surgery
☐ Heart Surgery
☐ Liver Transplant
☐ Pacemaker
☐ Appendectomy
☐ Kidney Transplant
☐ Blood Transfusion
☐ Gall Bladder Surgery
☐ Gastric Banding
☐ Amputation of:
☐ Other:

## 13. MEDICATIONS (Please provide a list of medications, dosage & frequency at first appointment)

| | Medication Name | Dosage | Frequency | Since When? |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |

## 14. PHARMACY INFORMATION

Pharmacy:

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

15. ALLERGIES (Please check all that apply)

| | | |
|---|---|---|
| ☐ None | ☐ Egg | ☐ Codeine |
| ☐ Aspirin | ☐ Latex | ☐ Iodine |
| ☐ Adhesive Tape | ☐ Local Anesthetic | ☐ General Anesthetic |
| ☐ Sulfa | ☐ Oak | ☐ Shellfish |
| ☐ Milk | ☐ Penicillin | ☐ Heparin |
| ☐ Other: | | |

16. DO YOU HAVE A (Please check all that apply)

Pacemaker
○ Yes ○ No

Back Stimulator
○ Yes ○ No

17. ATTESTATION I do hereby attest that this information is true, accurate and complete to the best of my knowledge. I understand that any falsifications, omissions, or concealment of any material fact may subject me to all fees for services and/or other liability. I also understand that I am to notify NSFAC immediately of any changes to the above information and I will be asked to do an annual update to this registration form annually.

PRINTED PATIENT NAME OR LEGALLY AUTHORIZED REPRESENTATIVE: _____ DATE: _____

RELATIONSHIP TO PATIENT: (If Authorized Representative) _____

Signature of Patient or Legally Authorized Representative:

_____ Signature _____ Date