Rhode Island Foot Care, Inc

PATIENT INFORMATION

Patient Name:_______________________________________ **Birthdate**:______________ **Age**: ________
(Last) (First) (Initial)

Sex: **M / F** **Home Phone**: ______________________ **Cell Phone**: ______________________

Address: ______________________________ **Email**:______________________________

City: ______________________ **State**: ________ **Zip**: ________ **SS#**: ______________________

Marital status: ☐ **Single** ☐**Married** ☐**Divorced** ☐ **Widowed** **Hispanic/Latino:** ☐ **Yes** ☐ **No**

Primary Language: ☐ English ☐ Spanish ☐ Other (Please Specify) ______________

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Patient Employed By: ______________________________ **Business Phone**:______________

Business Address:____

Is This Visit Work Related: ☐ **Yes** ☐ **No** **Authorization Number:**______________________

Emergency Contact: __________________ **Phone:** __________ **Relationship to Patient:**______________

Who may we thank for referring you? ______________________

Primary Care Dr: ______________________ **Phone:**______________ **Date of Last of Visit:**____________

Pharmacy: ______________ **Address:**______________________________ **Phone:** ______________

GUARANTOR

THE INFO GIVEN BELOW IS WHERE ALL STATEMENTS WILL BE SENT – THIS PERSON IS RESPONSIBLE FOR ALL CHARGES NOT COVERED BY INSURANCE

PLEASE CHECK IF GUARANTOR IS SAME AS PATIENT ☐

Name: ______________________________________ **Birthdate**:______________________

Address:__________________________ **City**:______________________ **State**:________ **Zip**:________

Social Security Number:______________________________ **Home Phone:**______________________

Place & Address of Employment:______________________________ **Work Phone:**______________________

PRIMARY INSURANCE

Insurance Company: ____

Group #: ______________ **Policy #:**______________________ **Policy Holder Name:**______________

Policy Holder's SS#:______________________________ **Policy Holder's Birthdate**: ______________

Relationship to Patient: __________________ **Policy Holder's Employer:**______________________

ADDITIONAL INSURANCE

Insurance Company: ____

Group #: ______________ **Policy #:**______________________ **Policy Holder Name:**______________

Policy Holder's SS#:______________________________ **Policy Holder's Birthdate**: ______________

Relationship to Patient: __________________ **Policy Holder's Employer:**______________________

AUTHORIZATION AND RELEASE

I, the undersigned, certify that I (or my dependent) have current insurance coverage and assign directly to Rhode Island Foot Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________________ ______________________________ ______________
Signature/Responsible Party (Relationship) (Date)

Rhode Island Foot Care, Inc.

PERSONAL HEALTH INFORMATION

Do you now or have you ever had:

	YES	NO		YES	NO		YES	NO
DIABETES	___	___	RHEUMATIC FEVER	___	___	ANEMIA	___	___
HEART DISEASE	___	___	RHEUMATOID ARTHRITIS	___	___	PHLEBITIS	___	___
HIGH BLOOD PRESSURE	___	___	GOUT	___	___	HEPATITIS	___	___
STROKE	___	___	EPILEPSY	___	___	ASTHMA	___	___
GLAUCOMA	___	___	THYROID PROBLEM	___	___	AIDS/HIV	___	___
KIDNEY DISEASE	___	___	LIVER DISEASE	___	___	CANCER	___	___
BLEEDING PROBLEMS	___	___	HEART MURMUR	___	___	GI ULCER	___	___

Other:____

____

What medications are you presently taking?

____

____

Do you have allergies to any medications? Yes / No

If yes, to what? ____

Social History:	Smoke:	Yes / No	How many packs per day? ________	How many years? ________
	Drink:	Yes / No	How many drinks per day? ________	How many years? ________
	Drug abuse:	Yes / No	If yes, what type(s)? ________________________	

Family History:

Please circle M and/or F to indicate Mother or Father:

DIABETES	M	F	RHEUMATIC FEVER	M	F	ANEMIA	M	F
HEART DISEASE	M	F	RHEUMATOID ARTHRITIS	M	F	PHLEBITIS	M	F
HIGH BLOOD PRESSURE	M	F	GOUT	M	F	HEPATITIS	M	F
STROKE	M	F	EPILEPSY	M	F	ASTHMA	M	F
GLAUCOMA	M	F	THYROID PROBLEM	M	F	AIDS/HIV	M	F
KIDNEY DISEASE	M	F	LIVER DISEASE	M	F	CANCER	M	F
BLEEDING PROBLEMS	M	F	HEART MURMUR	M	F	GI ULCER	M	F

Other:____

Surgical History:

____

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Please briefly describe your foot problem(s):

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Thank you for taking the time to provide us with this necessary information.
It will allow us to provide you with more thorough care of your foot problems.