

Sarasota Foot Care Center, PA

Please print clearly

Account Number _____

Name _____
(Last) (First) (Middle)

Local Address _____

City State Zip

Northern Address _____

City State Zip

Local Phone _____ Cell Phone _____ Northern Phone _____

Date of Birth _____ Age _____ Gender: ☐ Female ☐ Male Social Security # _____

Email Address _____

Race:	Ethnicity:	Smoking:	Marital Status:	Language:	Employment:	Student:
<input type="checkbox"/> Caucasian	<input type="checkbox"/> nonHispan	<input type="checkbox"/> Daily	<input type="checkbox"/> S	<input type="checkbox"/> English	<input type="checkbox"/> Full time	<input type="checkbox"/> Full time
<input type="checkbox"/> Black	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Some days	<input type="checkbox"/> M	<input type="checkbox"/> Spanish	<input type="checkbox"/> Part time	<input type="checkbox"/> Part time
<input type="checkbox"/> Asian		<input type="checkbox"/> Former	<input type="checkbox"/> D	<input type="checkbox"/> Other _____		
Other _____		<input type="checkbox"/> Never	<input type="checkbox"/> W			

Occupation _____ Employer _____ Phone _____

Work address _____

Next of Kin _____ SS# _____ DOB _____

Responsible party (for minor) _____ Relationship _____
(Last) (First)

Their employer _____ Occupation _____ Phone _____

Primary Insurance _____ Secondary Insurance _____

Name of policy holder _____ DOB _____ SS# _____

Is Insurance through employer? ____ Yes ____ No Yours or Spouse? _____

Pharmacy _____ Location _____ Phone # _____

IF WE CANNOT VERIFY YOUR INSURANCE BENEFITS BEFORE YOU ARE SEEN, YOU WILL BE ASKED FOR PAYMENT IN FULL

IF THIS VISIT IS RELATED TO A WORK INJURY, AUTO ACCIDENT, OR INVOLVES ANY TYPE OF LIGATION, PLEASE NOTIFY THE RECEPTIONIST IMMEDIATELY

I hereby authorize the release of any medical information necessary for processing claims and payment of medical benefits to myself or the party who accepts assignment (lifetime signature). I understand that, as the patient receiving medical treatment, I am responsible for payment regardless of insurance coverage or litigation.

Patient Signature _____ Date _____
(Responsible party)

(over)

Account Number: _____ SARASOTA FOOT CARE CENTER, PA

Name _____ Birthdate _____ Date _____

Height _____ Weight _____ Shoe size _____ Date of onset of symptoms _____

Reason for visit _____

Whom may we thank for referring you to our office? _____

Medical Doctor _____ Date last seen _____ Former Podiatrist _____

Medical History (check only those items that apply)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> GI Ulcers | <input type="checkbox"/> Leg cramps/numbness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Autoimmune disease | diet/oral/insulin _____ yr | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Peripheral neuropathy |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Hemoglobin A1c _____ | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Peripheral vascular dis |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Eye pathology | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Charcot joint | <input type="checkbox"/> Gastric reflux | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Osteoporosis |

Other Medical problems (please list) _____

Have you received the flu vaccine this season? Yes No

Have you received the pneumonia vaccine? Yes No

Surgical History (check only those items that apply)

- | | | | | |
|--|---------------------------------------|--|---|---|
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Cataract | <input type="checkbox"/> Gall bladder sx | <input type="checkbox"/> Kidney removal | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Heart by-pass | <input type="checkbox"/> Kidney stone sx | <input type="checkbox"/> Prostate surgery |
| <input type="checkbox"/> Arterial by-pass | <input type="checkbox"/> C-section | <input type="checkbox"/> Heart catheter | <input type="checkbox"/> Knee replacement | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Back surgery | <input type="checkbox"/> D and C | <input type="checkbox"/> Hernia repair | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Venous ligation |
| <input type="checkbox"/> Breast biopsy | <input type="checkbox"/> Endoscopy | <input type="checkbox"/> Hip replacement | <input type="checkbox"/> Neck surgery | |
| <input type="checkbox"/> Carotid artery sx | <input type="checkbox"/> Foot surgery | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Open heart sx | |

Other Surgery (please list) _____

Medications (please list) _____

Family History (please circle if positive)

	<u>Diabetes</u>	<u>Heart disease</u>	<u>Cancer</u>	<u>High blood pressure</u>
<u>Mother</u>	yes	yes	yes	yes
<u>Father</u>	yes	yes	yes	yes
<u>Siblings</u>	yes	yes	yes	yes

Current Activities and Social History (please check)

- ☐ Alcohol (frequency) _____ Tobacco _____ ppd Date quit _____ Caffeine (type) _____
- ☐ Physical Activities _____

Allergies (please check)

- | | | | |
|------------------------------------|-------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Novocaine | <input type="checkbox"/> Codeine | <input type="checkbox"/> Cortisone | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Adhesive tape | <input type="checkbox"/> Other _____ |

Review of systems (filled out by nurse)

Cardiovascular	hypertension / murmurs / chest pain / edema / claudication / ulceration / phlebitis / heart attack
Gastrointestinal	jaundice / cirrhosis / hepatitis / gastric reflux / GI ulcers / nausea / vomiting
Musculoskeletal	joint pain / joint swelling / muscle pain / poststatic dyskinesia / weakness / back pain
Dermatologic	rash / bleeding / bruising / pruritis / hypertrophic nails / ulcer / skin infection / psoriasis
Neurologic	paralysis / stroke / tics / tremors / seizures / tingling / numbness
Allergic/immunologic	allergies / anaphylactic reactions / HIV / immunosuppressed / recurring infections

Tech _____