Welcome To Our Office: Complete the following information for your file. (PLEASE PRINT)

Patient's Name (Last) (First) (M.I.)	Sex ☐Male ☐Female	Date of Birth	Age

Social Security Number	Home Phone Number	Cell Phone Number	Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other

Home Address	City	State	Zip Code

Name of Employer	Business Phone	Occupation

Primary Insurance Cardholder	Date of Birth	Relationship

Contact Name in Case of Emergency	Relationship

Family Physician Phone #	Are you currently under Physician's care? ☐No ☐Yes For What? Date Last Seen?

Who may we thank for referring you to our office?	Family History ☐Diabetes ☐Hypertension ☐Bleeding Disorders ☐Seizures ☐Foot Problems

Social History	Height Weight
Tobacco (ppd)_____ Caffeine (cpd)_____ Alcohol_____ Illicit Drug Use _____	

Please describe your chief foot/ankle complaint:

Have you been treated for this before?	What was done?	Previous doctor:

Past Medical History:

☐Cancer
☐Diabetes Type I/Type II
☐Hypertension
☐Bleeding Disorder
☐Gastric Ulcers
☐Gout
☐Joint Replacement
☐ Heart Disease
☐Kidney Disease
☐Liver Disease / Hepatitis
☐HIV/Aids
☐Thyroid
☐Arthritis
☐Phlebitis / Blood Clots
☐Stroke
☐Cholesterol
☐Other_____
_____

Please turn this form over and complete side two

Medications	Allergies	Reaction	Past Surgeries	Date

I hereby give Paul Angotti, D.P.M., Anthony Anzalone, D.P.M., George Morgan, D.P.M., Dara Friter D.P.M and Kimberly Wilkie, D.P.M. permission to administer treatment and perform such procedures as may be necessary for the diagnosis and treatment of my foot and/or ankle condition. Also, I authorize the release of any medical information necessary to process my claim. I also authorize payment to the above mentioned doctor(s) to keep my other medical care providers informed of my medical information, progress, and treatment obtained. I understand that as a courtesy, Foot & Ankle Specialty Center, P.C. will file all insurance claims for me and I am ultimately responsible for payment of all services rendered. If my account becomes overdue and remains unpaid for over 90 days it may go to collections, therefore, an additional $15.00 collection fee will be assessed and due from the patient.

Signature: Date:

Your email address _____