Foot Specialist Associates, PC

950 E. Harvard Suite 300
Denver, CO 80210

Phone: 303-722-6864
Fax: 303-722-5113

PLEASE *DO NOT* USE LOTIONS OR CREAMS ON YOUR FEET THE DAY OF YOUR APPOINTMENT

Patient Name: ______________________ Birth Date: ______________ Age: ______
Address: ______________________ Marital Status: ______________
City: __________ State: ______ Zip: ______ Soc Sec#: ______________ Gender: ______
Preferred Phone: ______________ ❑C ❑H ❑W Alt Phone: ______________ ❑C ❑H ❑W
Email (for appt reminders): ______________________
Employer: ______________________ Address: ______________________
Phone: ______________________ City: __________ State: ______ Zip: ______
Responsible Party: ______________________
Address: ______________________ City: __________ State: ______ Zip: ______
Birth Date: ______________________ Soc Sec#: ______________________
Phone: ______________________ Relationship: ______________________
Referred by: ______________________
Family Physician: ______________________ Physician Office Phone: ______________________
Pharmacy Name: ______________________ Pharmacy Phone: ______________________
Emergency Contact:
Name: ______________________ Phone: ______________________
Relationship: ______________________
Primary Insurance Information:
Policy ID: ______________________ Group ID: ______________________
Insurance Co. ______________________
Phone: ______________________
Insured Name: ______________________ Relationship: ______________________
Insured Birth: ______________________
Secondary Insurance Information:
Policy ID: ______________________ Group ID: ______________________
Insurance Co. ______________________
Phone: ______________________
Insured Name: ______________________ Relationship: ______________________
Insured Birth: ______________________

I am aware that my account and knowledge of insurance benefits is my responsibility. **Foot Specialist Associates, PC cannot guarantee payment, benefits or coverage from my insurance company.** I authorize my insurance benefits to be paid directly to Foot Specialists Associates, PC. I authorize the facility to release medical information for treatment, payment or daily operations. I voluntarily consent to examination and treatment for myself or the above dependent patient. I will inform Foot Specialist Associates, PC immediately of any insurance or personal information changes.

I have read all the above information and asked any necessary questions. I understand my obligations as outlined by this release.

Signature: ______________________________________ Date: ______________

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Medical History

Patient Name: ______________________ **Birth Date:** ______________

Describe your foot or ankle problem:

____

____

Past Medical History:

___ Anemia	___ Arthritis/Rheumatism	___ Asthma	___ Bleeding Disorder	___ Blood Clots
___ Bowel Disease	___ Cancer	___ Depression	___ Diabetes Type I	___ Diabetes Type II
___ Diphtheria	___ Epilepsy	___ Frequent Infections	___ Glaucoma	___ Gout
___ Heart Disease	___ Heart Murmur	___ Hepatitis	___ High Blood Pressure	___ HIV/AIDS
___ Measles/Mumps	___ Mental Illness	___ Mitral Valve Prolapse	___ Osteoporosis	___ Pacemaker
___ Peripheral Vascular	___ Polio	___ Rheumatic Fever	___ Rubella	___ Scarlet Fever
___ Skin Disease	___ Stomach Ulcers	___ Stroke	___ TB	___ Thyroid Disease
___ Varicose Veins	___ Venereal Disease			

Other: ____

Allergies - check all that apply:

___ Adhesive/tapes	___ Antihistamines	___ Asprin	___ Codeine	___ Demerol
___ Iodine	___ Latex	___ Mercurials	___ Merthiolates	___ Mycins/other
___ Novocain	___ Nylon/plastics	___ Penicillin	___ Sulfa	___ Tetanus antitoxin

Other: ____

Current Medications: Please list any prescriptions, over-the-counter meds and vitamins along with dosages, stregths and instructions:

____

____

When was your last tetanus shot? ______________________________

Have you ever had a blood transfusion? [ ]Yes [ ]No

Is there any chance you are pregnant? [ ]Yes [ ]No

HABITS:

Smoking: Daily Amount: ___________ Former Smoker? ___________ Never? ___________

Alcohol: Daily Amount: ___________

Caffeine: Daily Amount: ___________

Surgical History:

____

____

____

Injuries: (fractures, sprains, other). Please list injury and year

____

____

____

Family History:

Bleeding Disorder:	____ Mother	____ Father
Cancer:	____ Mother	____ Father
Diabetes:	____ Mother	____ Father
Epilepsy/convulsions:	____ Mother	____ Father
Glaucoma:	____ Mother	____ Father
Heart Disease:	____ Mother	____ Father
High Blood Pressure:	____ Mother	____ Father
Kidney Disease:	____ Mother	____ Father
Mental Illness:	____ Mother	____ Father
Osteoporosis:	____ Mother	____ Father
Stroke:	____ Mother	____ Father
Thyroid Disease:	____ Mother	____ Father

Other:

____

____

Agreement/Conditions of Treatment

I understand my physician(s) will use their best skill and judgment to accomplish the desired result.
I understand my physicians(s) cannot or does not warrant or guarantee such results.
The forecast of the length of time involved in therapy/recovery is based on similar cases as mine.
My result or response may be different from the usual.
On my part, I promise full cooperation in my treatment, whether by surgical or nonsurgical means.
I understand if I don't follow instructions, it could jeopardize the outcome and cause a negative result.

Signature: ____ Date: ____________________

Print Name: ____

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

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

______________________________	______________________________
Patient Name (please print)	Date

____
Parent or Authorized Representative

____
Signature