FOOT & ANKLE SPECIALISTS

WELCOME TO OUR OFFICE
(PLEASE PRINT)

Name_____ Date_____

Address,_____ City_____ State_____ Zip_____

Home Phone _____ Work Phone Social Security _____

Date of Birth_____ Age_____ Sex Female or Male (circle one) Marital Status S__ M__ D__W__

Referred By_____ Personal Physician _____

Employer_____ Address_____ City_____ State____ Zip_____

Name of Spouse, Parent or Next of Kin_____ Phone_____ Relationship_____

MEDICAL HISTORY

Describe your foot problem _____

_____

_____

How long has it been bothering you? ____ Days _____ Months____ Years____

Any Past Problems with your feet?_____

_____

_____

Shoe Size _____ Weight _____ Height _____

Are you allergic or sensitive to:

Antibiotics (Penicillin, Sulfa drugs etc.) Yes __ No__

Any Medicines Yes__ No__ If yes please specify _____

Tape Yes__ No__

Betadine (iodine) Yes__ No__

Other _____

Have you had any problems taking aspirin or ibuprofen (Advil, Motrin) Yes__ No__

Any problem with local anesthetics (Novocaine, LIdocaine) Yes__ No__

Do you have Diabetes Yes__ No__ If yes, do you take insulin? Yes__ No__ Number of years_____

Have you had any serious illnesses? Yes __ No__ Explain _____

Have you had any major surgeries? Yes___ No___ Explain_____

Family Physician _____ Date you last saw this Physician _____

Name of Pharmacy or Drug Store _____ Phone_____

Medications _____ _____

_____ _____

Check any of the following you have, or have had a problem with:

_____Heart _____Asthma _____Skin _____Unexplained weight loss

_____Circulation _____Stomach _____Gout _____Frequent Infections

_____Arthritis _____Hormones _____Tuberculosis _____Healing

_____Kidneys _____Anemia _____Rheumatic Fever _____Neurological Disorder

_____Lungs _____ Bladder _____Liver _____Intestines

_____Cancer _____High Blood Pressure

Do you have any artificial joints? Hip Yes ____ No____ Knee Yes ____ No____ Other_____

Do you have a Heart Valve Implant? Yes ____ No____

Family History

Mother Living _____ Deceased_____ Cause of Death_____

Father Living _____ Deceased_____ Cause of Death_____

Brother Living _____ Deceased_____ Cause of Death_____

Sister Living _____ Deceased_____ Cause of Death_____

Do you smoke? Yes _____ Number of packs per day _____ No_____

Previously smoked? Yes _____ Number of years_____ No_____

Do you drink alcohol? Yes_____ No_____ Light Usage_____ Moderate, 1-2 per day _____ Heavy, more than 2 per day _____

AUTHORIZATIONS I hereby authorize payment directly to the physician for the surgical and/or medical benefits. I also understand that I am responsible for any portion of my bill not covered by my insurance company. I understand that I am responsible for all co-pays and deductibles.

I hereby authorize release of information for insurance claim purposes the information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis syphilis, gonorrhea, HIV and AIDS.

I understand all of the above and hereby state the information is correct to the best of my knowledge.

Signed_____

Date_____

HIPPA AWARENESS: I am aware that BLACKSTONE VALLEY FOOT SPECIALIST is in compliance with HIPPA rules and regulations.