First Name: ________________________ MI: _____ Last Name: __________________________________

Address: ___________________________________ City: ____________ ST: ____ Zip: ___________

Primary Phone Number: ______________________ Secondary Phone Number: ____________________

Date of Birth: ________/_________/___________ Social Security Number: ______________________

Employer: __________________________________ Ocupation: __________________________________

Emergency Contact Name: _____________________ Contact Cell Number: _________________________

Primary Care Doctor: _________________________ Last Seen: __________________________________

Primary Pharmacy Name: _____________________ Primary Pharmacy Location: ___________________

How did you hear about us? __ Doctor __Family/Friend __Insurance __Social Media

Parent/Guardian's Name if Patient is a Minor: ______________________ Phone Number: __________________

Insurance Information

Co-Payment Amount: $___________ Deductible: $___________

Primary: ____________________________________ Secondary: __________________________________

Insured's Member ID#: ________________________ Insured's Member ID#: ________________________

Insured's Name: ______________________________ Insured's Name: ______________________________

Guarantor's SSN: XXX-XX-_________ Guarantor's SSN: XXX-XX-_________

Insured's DOB: _____/_____/________ Insured's DOB: _____/_____/________

Authorization for Treatment, Assignment, Release, & Office Policy

I hereby give Dr. Keith Nebeker and his staff permission to treat my feet and/or ankle disorders. I, the undersigned do assign directly to Dr. Keith Nebeker all medical benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the doctor to release all information necessary to secure payment of benefits. In addition, there is an office policy stating there is a charge of $40.00 for any no-show appointments and a $40.00 charge for any disability forms.

____ ________________________

Signature of Insured/Patient/Guardian Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made to Dr. Keith Nebeker for any services furnished. I authorize any holder of medication information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item nine of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, Dr. Keith Nebeker agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

____ ________________________

Signature of Beneficiary/ Guardian Date

Health Information Privacy Act (HIPA)

The Health Information Privacy Act of 2004 states that your medical information will not be shared with anyone except your insurance company for payment.

____ ________________________

Signature of Patient/ Guardian Date

Name: ______________________________________ Date: _______________

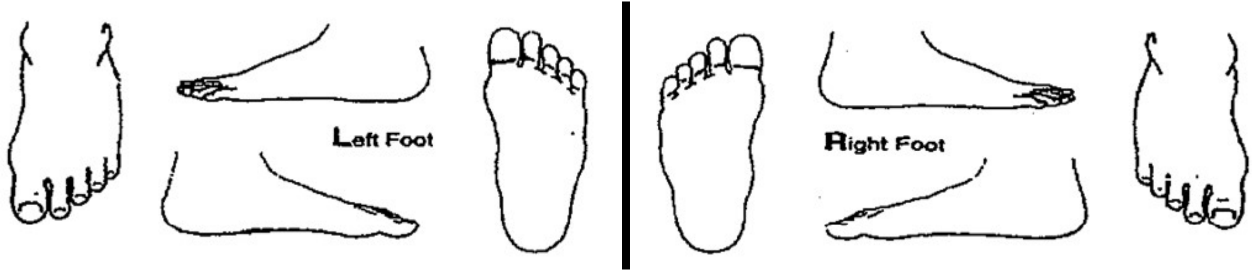
Chief Complaint
What is your main foot problem today? ____
Do you have any other foot problems that need attention? _____________________________

History of Present Illness

Symptoms
___ Arch Pain ___ Hip Pain ___ Ankle Pain ___ Pain in the balls of the feet
___ Heel Pain ___ Knee Pain ___ Low Back Pain

___ Other: ____

Location:
Mark on the diagram below the areas where each problem is located:



What Caused the Problem?
Trauma? ___ Yes ___ No What kind? ____

Duration- When did your problem begin? Date (if known) ___________
___ days ___ weeks ___ months ___ years ___unknown

What Makes it Worse? (i.e. walking, running, barefoot, wearing shoes, etc.)
____
____

What Makes it Better? (i.e. ice, heat, stretching, good shoes, etc.)
____
____

Quality:

___ Burning ___ Throbbing ___ Sharp ___ Dull ___ Aching
___ Tingling ___ Numbness ___ Itching ___ Other: ____________________

F. Keith Nebeker DPM
STEPPING FORWARD

Name: ____ Date: ________________

Severity

1	2	3	4	5	6	7	8	9	10
Mild Pain				**Please Circle**				Severe Pain	

Timing

___ Gradual ___Sudden ___Unknown

Previous Treatments

What previous treatments have been used?

Self: ____

Professional: ____

Allergies: ___ No Known Allergies

Antibiotic:	**Anti-Inflammatory:**	**Pain Med:**
___ Penicillin	___ Aspirin	___ Vicodin
___ Sulfa	___ Advil, Mortin, Ibuprofen	___ Codeine
___ Keflex	___ Aleve	___ Morphine
___ Other: ______________	___ Other: ______________	___ Tylenol

Other:

___ Novocain	___ Adhesive Tape	___ Metals	___ Egg
___ Iodine	___ Latex / Rubber	___ Shrimp	___ Other: ______________

Medications: ___ I do not take any medications.

Medicine / Dosage	How Often?	Reason for Taking
______________________________	______________	__________________________
______________________________	______________	__________________________
______________________________	______________	__________________________
______________________________	______________	__________________________
______________________________	______________	__________________________

Family History: Identify Type and Blood Relative

___ Arthritis ____

___ Cancer ____

___ Diabetes ____

___ Heart Disease____

___ High Blood Pressure ____

___ Neurological ____

___ Other (specify) ____

Name: ____ Date: _______________

Past Medical History: Circle if you now have or were ever treated for

AIDS
Alzheimer's / Dementia
Anemia
Asthma
Back Pain
Bleeding Disorders
Cancer- Type:____________
CHF

Diabetes- Insulin Dependent
Diabetes- Non-Insulin Dependent
Gout
Heart Disease- Type: ________________
Heart Murmur
Hepatitis- Type: ____________________
High Blood Pressure
Kidney Disease

Leg Cramps
Multiple Sclerosis
Neuropathy (Peripheral)
Parkinsons
Poor Circulation
Shortness of Breath
Stroke
Swelling of Feet / Ankles
Ulcer- Feet / Legs

Previous Foot Condition (Explain) ________________________ Other: _______________________

Social History:

Use of Alcohol: ___ Never ___ Social ___ Occasional ___ Light ___ Heavy (> 7 drinks/week)

Use of Tobacco: ____ Never Smoked ___ Current Smoker ___ Former Smoker- Quit? _____

Use of Smokeless Tobaco: ___ Never Used ___ Current User ___ Previous User- Quit?_____

Use of Drugs: ___ Never Used ___ Current User ___ Previous User- Quit? _____

Use of Recreational Marijuana: ___ Never Used ___ Current User ___ Previous User- Quit?_____

Surgical History: ___ Not applicable

Type of Surgery	Year	Type of Surgery	Year
________________________	_______	________________________	_______
________________________	_______	________________________	_______
________________________	_______	________________________	_______
________________________	_______	________________________	_______
________________________	_______	________________________	_______

Height ____________________ Weight ___________ Shoe size __________