MEDICAL FOOT CENTER
PATIENT INFORMATION FORM

DATE: ___/____/____

PATIENT NAME: ______________________________________ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
FIRST MI LAST

HOME ADDRESS: ____________________________________ CITY/STATE: __________________ ZIP: _________

SOCIAL SECURITY NUMBER: ____________________________

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (_______) ________-______________ YES NO

CELL PHONE #: (_______) ________-______________ YES NO

WORK PHONE #: (_______) ________-______________ YES NO

E-MAIL: ____

PROVIDING AN E-MAIL ADDRESS PROVIDES YOU WITH APPOINTMENT REMINDERS AND GIVES YOU SECURE ACCESS TO YOUR CLINICAL INFORMATION AND ON-LINE PATIENT RESOURCES THROUGH 'PATIENT FUSION'. ASK US IF YOU HAVE QUESTIONS.

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: ______________________ RELATIONSHIP: __________ PHONE #: (____) ____-______

EMERGENCY CONTACT: ______________________ RELATIONSHIP: __________ PHONE #: (____) ____-______

PRIMARY CARE DOCTOR: ___________________ WHO REFERRED YOU TO US? ______________________________

WERE YOU SEEN HERE BEFORE? YES NO FORMER NAME (IF APPLICABLE) ____________________________

OTHER SPECIALISTS YOU SEE: ____

PHARMACY: _______________________ LOCATION: _____________________ PHONE #: (____) ____-________

IS THERE A FAMILY MEMBER OR OTHER PERSON WITH WHOM WE MAY SHARE YOUR MEDICAL INFORMATION?

_____ YES NAME(S) ____

_____ NO

INSURANCE INFORMATION

WHO IS RESPONSIBLE FOR PAYMENT ? ________________________ RELATIONSHIP TO PATIENT? _____________

ADDRESS: ___________________ CITY/STATE: _____________ ZIP: _______ PHONE #: (____) ____-_____

PRIMARY INSURANCE COMPANY NAME: ____

INSURED NAME: ____________________ DATE OF BIRTH ___________ SSN ______________________

CONTRACT # ______________ GROUP # ________________

SECONDARY INSURANCE COMPANY NAME: ____

INSURED NAME: ____________________ DATE OF BIRTH ___________ EMPLOYER ______________________

CONTRACT # ______________ GROUP # ________________

PATIENT NAME:___________________________

MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

ALCOHOL USE: ☐ NEVER ☐ HISTORY OF ABUSE ☐ CURRENT USE - ________# DRINKS/WEEK.

TOBACCO USE: ☐ NEVER ☐ QUIT – HOW LONG AGO? ________ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

ILLICIT DRUGS: ☐ NEVER ☐ QUIT ☐ CURRENT USE-- TYPE ____________________

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: ____

EMPLOYER: ______________________ OCCUPATION: ______________________

RACE: ______________________ ETHNICITY: ☐ NON-HISPANIC ☐ HISPANIC ☐ NOT SPECIFIED

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ OTHER ____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ NONE KNOWN ☐ MEDICATIONS ______________________________
☐ ANESTHESIA ____________________ ☐ FOODS ______________________
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER ______________________

PATIENT NAME:______________________________

HAVE YOU EVER HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING?

Condition				Condition				Condition		
ACID REFLUX	Y	N		FIBROMYALGIA	Y	N		NEUROPATHY	Y	N
ANEMIA	Y	N		GOUT	Y	N		FOOT ULCERS	Y	N
ARTHRITIS	Y	N		HEART ATTACK	Y	N		PNEUMONIA	Y	N
ASTHMA	Y	N		HEART DISEASE/FAILURE	Y	N		POLIO	Y	N
BACK TROUBLE	Y	N		HEPATITIS ____	Y	N		RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N		HIV+/AIDS	Y	N		SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N		HIGH BLOOD PRESSURE	Y	N		SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N		KIDNEY DISEASE	Y	N		SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N		LIVER DISEASE	Y	N		STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N		LOW BLOOD PRESSURE	Y	N		STROKE	Y	N
CANCER:______________	Y	N		MIGRAINE HEADACHES	Y	N		THYROID DISEASE	Y	N
DIABETES	Y	N		MITRAL VALVE PROLAPSE	Y	N		TUBERCULOSIS	Y	N
OTHER CONDITIONS:										

WHAT FOOT/ANKLE PROBLEM BRINGS YOU IN: ____

____

NOTICE OF PRIVACY PRACTICES

WE KEEP A RECORD OF THE HEALTH CARE SERVICES WE PROVIDE YOU. YOU MAY ASK US TO SEE AND CORRECT YOUR RECORD. YOU MAY HAVE A COPY OF THAT RECORD; COPYING FEES APPLY. WE WILL NOT DISCLOSE YOUR RECORD TO OTHERS UNLESS YOU DIRECT US TO DO SO OR UNLESS THE LAW AUTHORIZES OR COMPELS US TO DO SO.

BY SIGNING BELOW, YOU ACKNOWLEDGE YOU WERE PROVIDED THIS NOTICE OF PRIVACY PRACTICES AND THAT YOU READ (OR HAD THE OPPORTUNITY TO READ) IT AND UNDERSTOOD THE NOTICE.

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

I CERTIFY THAT I HAVE COVERAGE WITH THE INSURER LISTED ABOVE AND ASSIGN DIRECTLY TO MEDICAL FOOT CENTER ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. MEDICAL FOOT CENTER MAY USE MY PRIVATE HEALTH INFORMATION FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING BENEFITS PAYABLE.

____ ____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE

____ ____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE