



Medical Foot Center

Contact Information

Patient Name: _____ Date of Birth: _____

Age: _____ Sex: M F SSN: _____ E-mail: _____

Mailing Address: _____ City, State: _____ Zip: _____

Primary Phone #: _____ OK to Text Secondary Phone #: _____ OK to Text

Have you been seen here previously? YES NO Former Name (if applicable): _____

Preferred Pharmacy: _____

Primary Care Doctor: _____ Who referred you to us? _____

Other specialists you see: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Do you have a legal guardian or healthcare power of attorney? YES NO

If yes, Name: _____ Relationship: _____ Phone #: _____

Is there a family member or other person with whom we may share your medical information? YES NO

If yes, Name: _____ Relationship: _____ Phone #: _____

What foot/ankle problem(s) brings you in today? _____

Insurance Information

Who is responsible for payment? _____ Relationship: _____

Address: _____ Phone, if different: _____

Primary Insurance Co: _____ ID#: _____

Secondary Insurance Co: _____ ID#: _____

Family History

Check all that apply: Diabetes Cancer Heart Disease High Blood Pressure Stroke

Coronary Artery Disease Thyroid Disease Rheumatoid Arthritis Other: _____

Name: _____

Medical History

Medications: _____

Prior surgeries with dates: _____

Hospitalizations other than surgery: _____

Allergies: No Known Yes, _____

Have you ever had any of the following:

Abnormal Bleeding	Y	N	Fibromyalgia	Y	N	Mitral Valve Prolapse	Y	N
Acid Reflux	Y	N	Foot Ulcers	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Pneumonia	Y	N
Arthritis _____	Y	N	Heart Attack	Y	N	Polio	Y	N
Asthma	Y	N	Heart Disease/Failure	Y	N	Rheumatic Fever	Y	N
Back Trouble	Y	N	Hepatitis _____	Y	N	Sickle Cell Disease	Y	N
Bladder Infections	Y	N	HIV+ /AIDS	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	High Blood Pressure	Y	N	Sleep Apnea	Y	N
Blood Transfusions	Y	N	Kidney Disease	Y	N	Stomach Ulcer	Y	N
Bronchitis/Emphysema	Y	N	Liver Disease	Y	N	Stroke	Y	N
Cancer: _____	Y	N	Low Blood Pressure	Y	N	Thyroid Disease	Y	N
Diabetes	Y	N	Migraine Headaches	Y	N	Tuberculosis	Y	N

Other Conditions: _____

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/week Daily

Types of Exercise: _____

Employer: _____ Occupation: _____

Race: _____ Ethnicity: Non-Hispanic Hispanic Not Specified

Notice of Privacy Practices

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 otherwise payable to me for services rendered. I understand that I am financially responsible for all unpaid charges. 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 all services and determining benefits payable.

Medical Foot Center keeps a record of all healthcare services provided to our patients. You may request to view and/or have a copy of your personal medical records (copying fees apply). We will not disclose your private medical information to others without your written consent, or as legally authorized by state and federal laws.

By signing below, I acknowledge all privacy practices as they have been written in this policy. I understand that it is my responsibility to request further information if needed.

Print Patient Name: _____ Patient/Guardian Signature: _____

Date: _____