WELCOME TO FAMILY FOOT CARE ASSOCIATES

Please Print

Date: _____ Patient's Soc. Sec. # _____

Patient's Legal Name _____

Address _____ City _____ State _____ Zip _____

E-mail Address _____

Home Phone _____ Birthdate _____ Age _____ Sex _____ Emergency No./Name _____

Marital Status (circle one) Single Married Widowed Divorced Separated

Height _____ Weight _____ Shoe Size _____

Due to government regulations, the following questions are required:

Race: _____ Ethnicity: _____ Nationality: _____

(Circle One: Hispanic or Latino Non Hispanic/Latino)

Language: _____ Dominant Hand: _____

Employer _____ Occupation _____

Work Phone _____

Spouse (Legal Name) _____ Employer _____

Occupation _____ Employer Phone _____

Parents (if minor) Mother _____ Father _____

Address _____

Occupations _____

Employers _____ Pharmacy _____

Family Physician _____

Are you allergic to any of the following or is there any allergy our office should know about?

❑ Aspirin ❑ Antihistamines ❑ Mycins ❑ Iodine ❑ Shellfish

❑ Codeine ❑ Local Anesthetics ❑ Penicillin ❑ Caffeine ❑ Sulfa

❑ Cortisone ❑ Adhesives/Tape ❑ Keflex ❑ Rubbing Alcohol ❑ Pollens ❑ Latex

❑ NO ALLERGIES ❑ Other _____

Are you pregnant? (Circle one) yes no

Tobacco Use - Smoke cigarettes: _____ Never _____ No _____ Yes

(If you never smoked please go to alcohol use question now)

Quit date: _____ How many years did you smoke? _____

Approximately how many packs a day did you smoke? _____

Current smoker: Packs/day: _____ # of years: _____

Other tobacco: _____ Pipe _____ Cigar _____ Snuff _____ Chew

Alcohol Use - Do you drink alcohol? _____ No _____ Yes

# of drinks/week: _____ Beer _____ Wine _____ Liquor

Drug Use - Have you had any prescriptions filled for Vicodin, Percocet, Oxycontin or any Narcotic in the past 12 months?

(Circle One) Yes No If yes, how many _____

Do you use marijuana or recreational drugs: _____ No _____ Yes

Have you ever used needles to inject drugs: _____ No _____ Yes

Are you currently taking any medications? Please list them or give us a list that we may copy: _____

_____

_____

List any surgeries you have had in the last 5 years _____

_____

_____

(Continued on back)

Have you ever had any problems with anesthesia? ❑ no ❑ yes

Please list any back, leg, ankle or foot injuries that you have had _____

_____

_____

What is your foot/ankle problem? _____

_____

_____

When did this problem begin?_____Accident Date_____

Please list any previous treatment you have had for this problem _____

_____

_____

How did you find out about our office?

_____Family Physician (name _____) ❑ Family ❑ Friend ❑ Internet ❑ Phone Book ❑ Advertisement

PERSONAL MEDICAL HISTORY: Do you have now (current) or have you had (past) any of the following conditions:

_____ NONE

Condition	Current	Past	Comments
Alcohol/Drug Abuse			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder/Kidney Problems			
Bleeding Disorder			
Blood Clot (leg)			
Blood Clot (lung)			
Blood Transfusion			
Cancer (Type_____)			
Cataracts			
Coronary Artery Disease			
Depression			
Diabetes (Type I)			
Diabetes (Type II)			
Diverticulosis			
Fractures (broken bones)			
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn/GERD)			
Glaucoma			
Heart Attack			
Heart Problems			
Hepatitis - Type A			
Hepatitis - Type B			
Hepatitis - Type C			
High Blood Pressure			
High Cholesterol			
HIV/AIDS			
Kidney Disease/Failure			
Leg Cramps			
Liver Disease			

(Personal Medical History continued)

Condition	Current	Past	Comments
Multiple Sclerosis			
Osteoporosis			
Pacemaker/Defibrillator			
Pheumonia			
Poor Circulation			
Raynauds Disease			
Seizure/Epilepsy			
Skin Condition (Eczema)			
Skin Condition (Psoriasis)			
Skin Condition (Abnormal Moles)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid High (Overactive)/Hyperthyroidism)			
Thyroid Low (Underactive)/Hyperthyroidism			
Varicose Veins			
Other (list)			

FAMILY HISTORY - Indicate which relative has had the following diseases (parents and siblings are most important.)

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
No significant history known										
Alcoholism / Drug Abuse										
Alzheimers										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer (Type)										
Colon Polyp										
Coronary Artery Disease (e.g. heart attack, angina)										
Depression / Suicide / Anxiety										
Diabetes (Type I)										
Diabetes (Type II)										
Emphysema (COPD)										
Genetic Disorder (explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis										
High Blood Pressure - Hypertension										
High Cholesterol										
Hip Fracture										
Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Osteoporosis										
Other (list)										

FAMILY
Foot Care

__" I hereby authorize my insurance company to remit payment to Family Foot Care, for services rendered. I also am aware that I am financially responsible for non-covered services, copayments, deductible and/or coinsurance balances"

___" I give authorization for Family Foot Care to release any information needed to process my claim"

__"I authorize Family Foot Care to obtain my medication history"

__CANCELLATION/"NO SHOW" APPOINTMENT POLICY
There will be a **$20** charge for all missed appointments. Kindly call 24 hours in advance to cancel or reschedule your appointment. Thank You

_____

Patient's name (please print)

_____

Patient or Guarantor Signature (responsible party) Date

(IF patient is a MINOR, under 18 years of age, please give name of parent or guardian, who is financially responsible for billing)

Name of
Parent/Guardian:_____

Address:_____

_____

Home/Cell Phone Number:_____
Date of Birth:_____
Social Security Number:_____
Employer Name/Address/Phone:_____

_____

_____

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

FAMILY
Foot Care

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 so chose) and understood the Notice. I also give consent to have communications from this office via telephone, email or text message.

Patient Name (please print) _____

Date _____

Parent or Authorized Representative (Print name if applicable) _____

Signature _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____
(please print)

Date of Birth: _____

I request that all communications to me (by telephone, mail or otherwise) by _____ [insert name of Practice] and/or its staff be handled in the following manner:

- For written communications: Address to: _____
  _____
  _____
  _____
- For oral communications: Call: _____
  (telephone number)
  May we leave a message?
  Yes ☐ No ☐

If the address provided above is not your home address or is not a street address, please provide us with a street address for purposes of ensuring payment:

_____
_____
_____

_____
Patient Signature

_____
Date

For Practice Use Only

Practice: ☐ Accepts ☐ Denies

Privacy Officer Signature: _____

Date: _____