FOOTCARE NOW™

Welcome to Our Office!

NEW PATIENT INTAKE FORM

Last Name: _____ **First name:** _____ **Gender: M F**

Date of birth: _____ **Age:** _____ **Social Security#:** _____

Address: _____ Apt# _____

City: _____ **State:** _____ **Zip:** _____

Cell phone: _____ **Home phone:** _____

Marital status: ___**Single** ___**Married** ___**Divorced** ___**Widowed** ___**Legally Separated**

Emergency contact: _____ **Phone:** _____**Relationship:** _____

Employment status: ___**Full-time** ___**Part-time** ___**Not employed** **Occupation:** _____

Preferred pharmacy: _____ **Phone:** _____

Primary Doctor: _____ **Phone:** _____

• • • Please describe your foot/ankle problem (include date and place of injury if applicable) • • •

_____

_____

_____

How did you hear about our practice? [ ] Google [ ] Facebook [ ] Instagram [ ] Twitter [ ] Insurance company

[ ] Family/Friend [ ] Doctor Referral [ ] Other: _____

Personal Medical History:

• • • Check those that apply to you now or have applied to you in the past • • •

Arthritis	No	Yes	Gastritis	No	Yes
Blood transfusion (year: _____)	No	Yes	Kidney disease	No	Yes
Cancer	No	Yes	Liver disorder	No	Yes
Diabetes	No	Yes	Psychiatric problem	No	Yes
Epilepsy/Seizure disorder	No	Yes	Respiratory disease / Lung disease	No	Yes
GI Disease (ulcers)	No	Yes	Stroke	No	Yes
Heart Disease	No	Yes	Thyroid disease	No	Yes
Hepatitis	No	Yes	Vascular disease / Circulatory problems	No	Yes
Hypertension (high blood pressure)	No	Yes	Hypercholesterolemia	No	Yes
HIV or other immune deficiency	No	Yes	Asthma	No	Yes

MEDICATIONS

Please list all current medications:

1. _____ **6.** _____

2. _____ **7.** _____

3. _____ **8.** _____

4. _____ **9.** _____

5. _____ **10.** _____

ALLERGIES

____Medications:_____

____Foods:_____

____Other:_____

SURGICAL HISTORY

Surgical Procedures/Serious Injuries/Illnesses	Year	Physician	Hospital

Has any **family member** had any of the following (please indicate relationship):

Cancer:_____Diabetes:_____

Heart disease:_____Stroke:_____

High blood pressure: _____ Vascular disease/Circulatory problems:_____

Other: _____

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PATIENT SOCIAL INFORMATION

Do you smoke currently? _____Yes_____No How many Packs per day? _____For how many years?_____
Have you smoked previously? _____Yes_____No When did you quit_____
History of substance abuse? _____Yes_____No If yes, please list them:_____
Amount of alcohol consumed: **Per week**_____ **Per month**_____

MEDICAL CONDITIONS

• • • Check those that ***currently*** apply to you • • •

Blackout/fainting	No	Yes	Headache	No	Yes
Bladder/bowel movement	No	Yes	High blood pressure	No	Yes
Bleeding problems	No	Yes	Lower back pain	No	Yes
Changes in skin color /texture	No	Yes	Lungs, breathing,/ cough	No	Yes
Chest pain/palpitation	No	Yes	Muscle/bone/joint pain	No	Yes
Digestion	No	Yes	Numbness/ tingling	No	Yes
Ears, Nose, Throat	No	Yes	Swelling discoloration extremity	No	Yes
Eyes/visual disturbance	No	Yes	Weight loss or gain	No	Yes
Fever/chillis/sweats/fatigue	No	Yes	Dizziness	No	Yes

I hereby authorize direct payment of surgical and medical benefits on my behalf to the provider of these services that I would otherwise be payable to me if I did not make this assignment. I understand that I am personally responsible to the physician for charges not covered by my insurance agreement. I permit a copy of this assignment to be used in place of the original for purposes of billing.

I acknowledge that if my insurance requires a referral, whether it be paper or electronic, that I am responsible for getting an up to date and valid referral.

The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital generated. Also, I herby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition to use x-ray examination, or photographs as necessary.

I give Footcare Now permission to obtain and release medical information to insurance companies and referring physician. I have read the following and understand and agree to Footcare Now's office policy.

_____ _____
DATE SIGNATURE OF PATIENT OR LEGAL GUARDIAN

* If not patient, relation to patient:
___Parent___Power of attorney___Legal guardian__Other:_____