PATIENT INFORMATION AND MEDICAL HISTORY

MISS MS MRS MASTER MISTER MR SPOUSE'S NAME_____

PATIENT'S NAME_____ SS# OF PATIENT_____

ADDRESS_____CITY_____STATE_____ZIP_____

DATE OF BIRTH_____AGE_____CELL PHONE#_____VOICE MAIL?_____

HOME PHONE#_____MSG/EMERGENCY#_____NAME/RELATION_____

YOUR EMPLOYER_____WORK#_____

SPOUSE'S EMPLOYER_____SPOUSE'S DOB_____SS#_____

RESPONSIBLE PARTY'S NAME_____PHONE#_____RELATIONSHIP_____

RESPONSIBLE PARTY'S ADDRESS_____CITY_____STATE_____ZIP_____

THEIR SS#_____DOB_____EMPLOYER_____

PATIENT'S FAMILY DOCTOR_____CITY/STATE_____

PATIENT'S PHARMACY_____PHONE#_____

HOW DID YOU HEAR ABOUT OUR CLINIC (Referred by)?_____

PRIMARY INSURANCE COVERAGE_____ID#_____

GROUP#_____EFFECTIVE DATE_____

NAME OF POLICY HOLDER_____RELATION TO PATIENT_____

MAILING ADDRESS OF POLICY HOLDER_____

SS# OF POLICY HOLDER_____BIRTHDATE OF POLICY HOLDER_____

EMPLOYER OF POLICY HOLDER_____

SECONDARY INSURANCE COVERAGE_____ID#_____

GROUP#_____EFFECTIVE DATE_____

POLICY HOLDER_____RELATION TO PATIENT_____

MAILING ADDRESS OF POLICY HOLDER_____

SS# OF POLICY HOLDER_____DOB_____EMPLOYER_____

PLEASE READ AND SIGN BELOW

Your insurance policy is a contract between you and your insurance company.
You are responsible to pay your patient share at the time of each visit.
Patients without health insurance coverage are expected to pay for services prior to each visit.

By signing below, you acknowledge that your insurance company may not pay 100% of allowed charges, and you are responsible to pay any amounts due. You also agree to have your insurance company pay directly to Arkansas Foot Clinic for medical and/or surgical care.

_____

SIGNATURE (Patient or Parent/Guardian, if Minor) DATE

NAME_____DATE_____

PLEASE CIRCLE ANY OF THE FOLLOWING ILLNESSES YOU HAVE OR HAVE HAD

Asthma	Diabetes Type I or Type II	Arthritis	Thyroid Disorders
Ulcers	Insulin____Pills____	Kidney Disorders	MVP
Ankle Swelling	High Blood Pressure	Liver Disorders (Hepatitis)	High Cholesterol
Heart Disorders	Poor Circulation	Rheumatic Fever	Ear Disorders
Free Bleeding	Lung Disorders	Stroke	Eye Disorders
HIV	Blood Clots	Neurological Disorders	Psychiatric Disorders
Gout	Anemia	Seizures/Epilepsy	Cancer

List any illnesses you have or have had that are not listed above_____

List family history of illnesses_____

LIST ALL SURGERIES YOU HAVE HAD AND WHEN_____

_____

_____

List when and where you have received a blood transfusion_____

Circle any implants you have: HIP KNEE HEART VALVE SCREWS RODS PINS OTHER_____

PLEASE CIRCLE ANY OF THE FOLLOWING YOU ARE ALLERGIC TO

Local Anesthetic (Novocain)	Iodine	Codeine	Sulfa Drugs
Demerol	Penicillin	Aspirin/NSAIDs	Adhesive Tape/Latex

Type of reaction_____

List any other allergies not listed above and your reaction_____

WEIGHT_____HEIGHT_____SHOE SIZE_____

Do you use tobacco? No____Yes____ Smoke____Packs per day?_____Chew/Dip____Frequency?_____

Do you drink alcohol? No____Yes_____ 1 - 2/week 1 - 2/day 2 +/day

LIST ALL CURRENT MEDICATIONS (Name/Dosage)_____

_____

_____

DESCRIBE YOUR FOOT/ANKLE PROBLEM_____

_____

_____

How long has the problem existed?_____Have you consulted a doctor?_____When/Where?_____

How have you tried to relieve the problem?_____