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Last Name:______________________ First Name:______________________ MI:__________

Address: ______________________ City: ______________ State:________ Zip:__________

Home # (____) ______________ Cell # (____) ______________ Work # (____) ______________

Emergency Contact:______________________ Phone: (___) __________ Relationship: __________

E-Mail: ______________________________

Family Physician: ______________________________ Phone Number: (____) ______________

Fax Number: (____) ______________

Birth Date: _____/_____/______ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer:____________________ Employer Address:______________________________

__FULL TIME__PART TIME __NOT EMPLOYED __SELF EMPOYED__RETIRED __ACTIVE MILITARY DUTY __STUDENT

Pharmacy: ______________________________ Pharmacy Phone Number: (___) ______________

Referred by: ______________________________

HOW DID YOU HEAR ABOUT US: **Doctor Referral** ☐ **Insurance** ☐ **Friend/Family** ☐ **Internet/Google** ☐

Referred by:____________________________ *Other:*______________________

RELEASE OF PERSONAL INFORMATION TO THE PATIENT'S DESIGNEES

I authorized medical staff members of this practice to discuss my medical history, diagnosis, treatment and prognosis with other medical providers and organizations that participate in care and with those listed below.

Name Phone Number Relationship

____

____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits and services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, ____________________________ , herby authorize______________________________ to pay and hereby assign directly to Family Foot & Ankle Care all benefits. I further acknowledge that any insurance benefits, when received by and paid to Family Foot & Ankle Care, will be credited to my account in accordance with the above said assignment.

Agreed & Authorized: ______________________________ **Date**: ______________

SOCIAL HISTORY

Do or Did you smoke cigarettes? ☐Yes ☐No If Yes, packs per day?_______ Stop date: ______________

Drink alcohol regularly? ☐Yes ☐No Do you exercise regularly? ☐Yes ☐No

Allergies to any medication? ☐Yes ☐No If Yes, which medications? ______________________

Place of Birth? ____________________ Unusual Occupational Exposures? ______________________

Please list ALL medications you are currently taking: ______________________________

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MEDICAL HISTORY:

Previous Surgery/Hospitalizations____

____

Blood Transfusions (dates): ____________________________ General Anesthesia:___________________________

Injuries and Fractures (types & dates): ____

FAMILY HISTORY (check if anyone in your family has had or had the following)

	MOTHER	FATHER	SIBLINGS	CHILDREN	OTHER RELATIVE
CANCER					
DIABETES					
HEART DISEASE					
ARTHRITIS					
OSTEOPOROSIS					
AGE (IF LIVING)					

SYSTEMIC REVIEW (DO YOU NOW HAVE OR EVER HAD THE FOLLOWING)

	YES	NO		YES	NO
Chronic Headaches/Migraines			**Diabetes**		
Dizziness			**High Blood Pressure**		
Fainting Spells/Blackouts			**High Cholesterol**		
Eye Disease/Glaucoma/Cataracts			**Joint Pains/Swelling**		
Double Vision			**Swelling of ____Feet ______Ankles**		
Recent Vision Impairment			**Numbness/Tingling of hand/Feet**		
Impaired Hearing			**Color Changes in the Hands**		
Ringing in the Ears			**Chest Pressure/Chest Pain**		
Dryness of _____Eyes _____Mouth			**Chronic Back Pain**		
Recent Hair Loss			**Chronic Neck Pain**		
Asthma			**Parkinsonism**		
Recurrent Fever			**Osteoporosis**		
Thyroid Disorder			**Sciatica**		
Pneumonia			**Anemia or Blood Disorder**		
Pleurisy			**Skin Rash**		
Frequent Cough			**Psoriasis**		
Tuberculosis Exposure			**Recent Weight ____Gain _____ Loss**		
Difficulty Breathing			**Loss of Appetite**		
Coughing Up Blood			**Constant Thirst or Hunger**		
Rheumatic Fever			**Stomach/Duodenal Ulcer**		
Difficulty Urinating			**Abdominal Pain/Heart Burn**		
Painful/frequent Urination			**Frequent Nausea/Vomiting**		
Blood in Urine			**Heart Murmur**		
Nighttime Urination ______Times			**Cancer**		
Prostate Disorder			**Palpitations**		
Recurring Bladder Infections			**Convulsions OR Epilepsy**		
Kidney Disease/Stones			**Hepatitis/Jaundice**		
Pancreatitis			**HIV Virus Positive**		
Diverticulitis			**Chronic Anxiety**		
Phlebitis			**Depression**		
Insomnia					

Date of: Most Recent Medical Exam _____________________

EKG _______________ Blood Tests _______________ Chest X-Ray _______________

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