

WELCOME TO Foothills Podiatry, P.A.
CONFIDENTIAL PATIENT INFORMATION

Last First Middle/Maiden Name You Prefer

Mailing/Street Address City/State/Zip

Home Phone (____)____-____ Age ____ Sex ____ Date of Birth ____/____/____

Social Security#: _____ Height _____ Weight _____ Shoe Size _____

Marital Status: __ Married (Spouse Name: _____) __ Single __ Widowed __ Divorced

E-Mail Address: _____

Patient's Employer: _____ Spouse's Employer: _____

Address: _____ Address: _____

Work Phone#: _____ Work Phone #: _____

Responsible Party Information (If different than patient)

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City/State/Zip: _____ Social Sec.#: _____

Date of Birth: _____ Employer: _____

IF ASSIGNMENT IS TAKEN, I AUTHORIZE MY INSURANCE/MEDICARE BENEFITS TO BE PAID DIRECTLY TO FOOTHILLS PODIATRY, P.A. AND AUTHORIZE RELEASE OF INFORMATION ACQUIRED IN THE COURSE OF TREATMENT IN ORDER TO PROCESS CLAIMS. I AM FINANCIALLY RESPONSIBLE FOR ALL RENDERED SERVICES.

I ALSO AUTHORIZE RELEASE OF MEDICAL INFORMATION TO MY PRIMARY CARE PHYSICIAN. BY SIGNING BELOW, I AGREE TO THE ABOVE AND GRANT FOOTHILLS PODIATRY, P.A. PERMISSION FOR EVALUATION AND TREATMENT OF MY MEDICAL CONDITION.

*****PAYMENT IS EXPECTED AT TIME OF SERVICE*****

*****WE WILL FILE YOUR INSURANCE AS A COURTESY FOR YOU*****

Date: _____ Signature: _____

FOOTHILLS PODIATRY, P.A.
HEALTH HISTORY

Date ___/___/___ Male / Female ACCT#: _____
Referred By: _____

Name _____ DOB ___/___/___ Age ___ Family MD _____

What is the reason for this visit? _____

Location (Right or Left and area): _____

When did it begin? _____ Injury? _____ Date: _____

Describe pain (sharp, dull, constant, etc.): _____

Anything aggravate or alleviate it? _____

Any treatment (self or doctor)? _____

Current Medications (Name & Dosage): _____

Pharmacy Name & Phone #: _____

Allergies & Reaction (Example: Codeine-rash)

Codeine _____	Penicillin _____	Latex _____	Other _____
Aspirin _____	Sulfa _____	Novocain _____	_____
Anesthetics _____	Adhesive tape _____	Iodine _____	No known allergy _____
Foods _____	Neosporin _____	IVP Dye _____	

Medical Conditions –YOU have or Had in the past

___ Aids (HIV)	___ Arthritis	___ Bowel Disorder	___ Seizures/Epilepsy
___ Alcoholism	___ Asthma	___ Cancer	___ Pregnant
___ Anemia	___ Bleeding Disorder	___ Diabetes	___ Gout

Medical Conditions-continued

- | | |
|---|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Liver Ds-Hepatitis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Nerve Problems | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Currently Breast Feeding | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Other _____ |

List All surgeries & Year: _____

List All Serious Illness/Injuries & Year: _____

Health Habits (use & amount)

- | | |
|---|--|
| <input type="checkbox"/> Caffeine _____ | <input type="checkbox"/> Tobacco _____ |
| <input type="checkbox"/> Drugs _____ | <input type="checkbox"/> Alcohol _____ |
| <input type="checkbox"/> Other _____ | |

Occupation: _____

Hobbies: _____

Family History

Relation	Age	Age of Death	Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brother(s)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Sister(s)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Medical Conditions that family members have:

Disease Relationship (m-mother, f-father, b-brother, s-sister)

___ Arthritis/Gout	_____
___ Asthma	_____
___ Cancer	_____
___ Addictions to:	_____
___ Diabetes	_____
___ Heart/Stroke	_____
___ High Blood Pressure	_____
___ Kidney Disorder	_____
___ Tuberculosis	_____
___ Other	_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor, nurse or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I also give permission to release medical records to the referring doctor, insurance company or employer.

Signature _____ Date: _____

Reviewed by: _____ Date: _____

Reviewed by: CJM _____ RAM _____ Date: _____

**IN ORDER TO BE SEEN:
ALL NEW PATIENTS
MUST BRING THEIR
INSURANCE CARDS
AS WELL AS
A LIST OF THEIR
MEDICATIONS OR
BRING THE MEDICATIONS
IN ON THE FIRST VISIT!!!!**