FOOTHILLS
PODIATRY, P.A.
Family foot care since 1932.

FOOTHILLS PODIATRY
707 North Morgan Street Shelby, NC 28150 | **Phone:** (704) 487-6672
Fax: (704) 487-7863 | **Web:** www.foothillspodiatry.com

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WELCOME TO OUR PRACTICE!

Please print this off and bring it with you on your first visit!

YOU WILL NEED TO BRING YOUR INSURANCE CARDS AND MEDICATIONS WITH YOU ON YOUR APPOINTMENT.

IF YOU DO NOT HAVE THEM WE WILL NEED TO RESCHEDULE YOUR APPOINTMENT.

THANK YOU!

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PATIENT HISTORY

GENERAL INFORMATION

Name_____ _____
Last First Middle/Maiden Name you Prefer

Address_____
Street City State/Zip

Home Phone (_____) _____-_____ **Cell Phone** (_____) _____-_____

E-Mail Address_____

Age_____ **Sex**_____ **Date of Birth**_____/_____/_____ **Social Security#** _____

Height_____ **Shoe Size**_____ **Race**_____ **Language**_____ **Ethnicity**_____**Weight**_____

Married _____ (**Spouse's Name**_____) (**Spouse's Email**_____)
Single_____**Widowed**_____ **Divorced**_____

Patient's Employer:_____ **Work Phone:** _____

Work Address: _____

Spouse's Employer: _____ **Work Phone:** _____

Work Address: _____

RESPONSIBLE PARTY INFORMATION *(If different than patient)*

Name:_____ **Date of Birth** _____/_____/_____

Relationship To Patient _____ **Social Security #:** _____

Address: _____

Home Phone (_____) _____-_____ **Cell Phone** (_____) _____-_____

Employer: _____

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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:_____

PLEASE CHECK METHOD OF PAYMENT: _____-Cash _____-Check _____-Credit Card

PLEASE GIVE RECEPTIONIST YOUR INSURANCE CARD(S).
PLEASE READ AND COMPLETE ALL PAGES. THANK YOU.

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HEALTH HISTORY

Acct#: _____

Date_____/_____/_____ **Male / Female** **Referred By:** _____

Name_____ **DOB**_____/_____/_____ **Age**_____ **Family MD:**_____

What is the reason for this visit? _____
_____

Location (Right or Left / Area):_____

When did it begin? _____

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

Injury? _____ **Date & Time of Injury:** _____

Anything aggravates or alleviates it? _____

Any treatment (self or Dr.)? _____

List all current Medications (Name & Dosage): _____
_____
_____
_____
_____

Pharmacy Name & Location: _____

ALLERGIES & TYPE OF REACTION: (Example: Codeine-Rash)

None _____	Penicillin _____	Novocain _____
Codeine _____	Sulfa _____	Iodine _____
Aspirin _____	Adhesive tape _____	IVP Dye _____
Anesthetics _____	Neosporin _____	Other _____
Foods _____	Latex _____	

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MEDICAL CONDITIONS - YOU have or had in the past.

_____Aids (HIV)	_____Gout	_____Poor Circulation	_____Currently Pregnant
_____Alcoholism	_____Heart Disease	_____Rheumatic Fever	_____Breast Feeding
_____Anemia	_____High blood pressure	_____Scarlet Fever	_____Hiatal Hernia
_____Arthritis	_____Kidney Disease	_____Stroke	_____Other:_____
_____Asthma	_____Liver DS-Hepatitis	_____Thyroid Disorder	
_____Bleeding disorder	_____Mental Health	_____Tuberculosis	
_____Bowel disorder	_____Multiple Sclerosis	_____Ulcers	
_____Cancer	_____Nerve Problems	_____Varicose Veins	
_____Diabetes	_____Phlebitis	_____Venereal Disease	
_____Seizures/Epilepsy	_____Polio	_____Fibromyalgia	

List All Surgeries & Year: _____
_____
_____
_____

List All Serious Illness/Injuries & Year: _____
_____
_____
_____

HEALTH HABITS (USE & AMOUNT)

_____Caffeine _____ _____Tobacco _____
_____Drugs _____ _____Alcohol _____
_____Other _____

Occupation: _____ **Hobbies:** _____

FAMILY HISTORY:

Relation	**Age**	**Age of Death**	**Cause of Death**
Father	_____	_____	_____
Mother	_____	_____	_____
Brother's	_____	_____	_____
	_____	_____	_____
Sister's	_____	_____	_____
	_____	_____	_____

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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 Press.	_____
_____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 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:** _____/_____/_____