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!
GENERAL INFORMATION

Name ___________________________________________ Middle/Maiden Name you Prefer

Last   First

Address ___________________________________________ City State/Zip

Street

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: ___________________________________________
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.
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 ___________  Sulfur _____________  Iodine ___________
Aspirin ___________  Adhesive tape ___________  IVP Dye ___________
Anesthetics __________  Neosporin ___________  Other ______________
Foods _______________  Latex _______________

HEALTH HISTORY
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:

<table>
<thead>
<tr>
<th>Relation</th>
<th>Age</th>
<th>Age of Death</th>
<th>Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brother's</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister's</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MEDICAL CONDITIONS THAT FAMILY MEMBERS HAVE:

<table>
<thead>
<tr>
<th>Disease</th>
<th>Relationship (M-mother, F-father, B-brother, S-sister)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis-Gout</td>
<td>____________________________________________________</td>
</tr>
<tr>
<td>Asthma</td>
<td>____________________________________________________</td>
</tr>
<tr>
<td>Cancer</td>
<td>____________________________________________________</td>
</tr>
<tr>
<td>Addictions to:</td>
<td>____________________________________________________</td>
</tr>
<tr>
<td>Diabetes</td>
<td>____________________________________________________</td>
</tr>
<tr>
<td>Heart-Stroke</td>
<td>____________________________________________________</td>
</tr>
<tr>
<td>High Blood Press.</td>
<td>____________________________________________________</td>
</tr>
<tr>
<td>Kidney Disorder</td>
<td>____________________________________________________</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>____________________________________________________</td>
</tr>
<tr>
<td>Other:</td>
<td>____________________________________________________</td>
</tr>
</tbody>
</table>

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: ______/_____/__________