NORTHWEST PODIATRY CENTER, LTD.

DISEASES AND SURGERY OF THE FOOT AND ANKLE

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WELCOME: Thank you for choosing Northwest Podiatry Center for your foot care needs. Below are question to help us get better acquainted and provide information vital to your health. Please feel free to discuss matters of a private nature with the doctor. This information will be kept confidential. ****PLEASE COMPLETE *ALL* INFORMATION ON *BOTH* SIDES OF FORM *****

PATIENT INFORMATION

NAME: (LAST)_____ (FIRST)_____ (M.I.)_____

ADDRESS:_____ CITY:_____ ST:_____ ZIP:_____-_____

HOME PHONE#:_____ WORK PHONE#:_____ CELL PHONE#:_____

BIRTH DATE:_____ AGE:_____ SOCIAL SECURITY#:_____ ☐ MALE ☐ FEMALE

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED RACE:/Ethnicity_____ HT:_____ WEIGHT:_____SHOE SIZE:_____

EMPLOYER:_____ EMPLOYER ADDRESS:_____ OCCUPATION:_____

YOUR INSURANCE CO.:_____ ID#_____ POLICY#_____

MEMBER/NAME OF INSURED

☐ PATIENT ☐ SPOUSE ☐ FATHER ☐ MOTHER ☐ OTHER:_____ NAME:_____

TYPE INSURANCE: ☐ HMO ☐ PPO ☐ POS ☐ MEDICARE ☐ OTHER:_____ CO-PAY: ☐ YES ☐ NO AMOUNT OF CO-PAY: $_____

SPOUSE INFORMATION

NAME: Last_____First_____M.I._____ BIRTH DATE:_____ SOCIAL SECURITY#_____

EMPLOYER:_____ OCCUPATION:_____ BUS. PHONE#_____

EMPLOYER ADDRESS:_____ CELL PHONE#_____

PARENT OR GUARDIAN INFORMATION

FATHER NAME: Last_____ _____Firsrt_____M.I. _____

ADDRESS:_____

CITY:_____ ST:_____ ZIP:_____

HOME PHONE#_____ CELL PHONE#_____

FATHER'S SOC. SECURITY#_____ BIRTH DATE:_____

EMPLOYER:_____ OCCUPATION:_____

BUS. ADDRESS:_____

BUS. PHONE#_____

MOTHER NAME: Last_____First_____M.I____

ADDRESS:_____

CITY:_____ ST:_____ ZIP:_____

HOME PHONE#_____ CELL PHONE#_____

MOTHER'S SOC. SECURITY#_____ BIRTH DATE:_____

EMPLOYER:_____ OCCUPATION:_____

BUS. ADDRESS:_____

BUS. PHONE#_____

SECONDARY INSURANCE

DO YOU HAVE SECONDARY INSURANCE? ☐ YES ☐ NO

NAME OF POLICY HOLDER FOR SECOND INSURANCE:_____

PATIENT'S RELATIONSHIP TO THE POLICY HOLDER: ☐ SELF ☐ SPOUSE ☐ FATHER ☐ MOTHER ☐ OTHER

NAME OF SECONDARY INSURANCE COMPANY:_____ ID#_____ POLICY#_____

OFFICE VISIT INFORMATION

1. WHAT BRINGS YOU TO THE OFFICE TODAY _____
2. HOW LONG HAS IT BOTHERED YOU? ☐ DAYS ☐ WEEKS ☐ YEARS
3. IS THIS A WORK RELATED INJURY? ☐ YES ☐ NO
4. ANY PAST PROBLEMS WITH YOUR FEET OR ANKLES? ☐ YES ☐ NO PLEASE DESCRIBE_____

_____

5. HOW WERE REFERRED TO OUR OFFICE? ☐ SELF HOW?_____ ☐ OTHER HOW?_____

☐ NEWSPAPER ☐ YELLOW PAGES ☐ MAILER TO HOME ☐ INSURANCE DIRECTORY ☐ INTERNET AD ☐ FRIEND ☐ PATIENT ☐ DOCTOR ☐ RELATIVE

NAME:_____Address_____

6. EMERGENCY CONTACT:_____ RELATION:_____ PHONE# (_____)_____

7. FAMILY DOCTOR OR CLINIC:_____ LAST VISIT:_____

8. ADDRESS:_____ PHONE# (_____)_____

9. WOULD YOU LIKE YOUR PODIATRIC REPORT SENT TO YOUR MEDICAL DOCTOR? ☐ YES ☐ NO FAX# (_____)_____

10. ARE YOU TAKING ANY MEDICATIONS? ☐ YES ☐ NO **If yes please list with dosage amounts** _____

Pharmacy name_____Phone_____Fax_____

Pharmacy address_____

11. ARE YOU ALLERGIC OR SENSITIVE TO: ☐ **NO ALLERGIES** ☐ ASPIRIN ☐ BETADINE (IODINE) ☐ CODEINE ☐ IBUPROFEN ☐ PENICILLIN
☐ SULFA ☐ TAPE OR BAND-AID ☐ TYLENOL ☐ OTHER:_____

12. DO YOU HAVE OR HAVE YOU HAD A PROBLEM WITH ANY OF THE FOLLOWING?

☐ ANEMIA	☐ DIABETES	☐ HYPERTENSION	☐ PREGNANT	☐ WATER RETENTION (EDEMA)
☐ ARTHRITIS	☐ GOUT	☐ INTESTINES	☐ RHEUMATIC FEVER	☐ WEIGHT LOSS (UNEXPLAINED)
☐ ASTHMA	☐ HEALING	☐ KIDNEYS	☐ SKIN	☐ THYROID
☐ BLADDER	☐ HEART	☐ LIVER	☐ STOMACH ULCERS	☐ HIGH CHOLESTEROL
☐ CANCER	☐ HEART MURMUR	☐ LUNGS	☐ TB	☐ **NONE**
☐ CIRCULATION	☐ HORMONES	☐ NEUROLOGICAL DISORDERS	☐ VISION	Other_____

13. HAVE YOU HAD ANY SURGICAL PROCEDURES OTHER THAN FOOT OR ANKLE? ☐ YES ☐ NO IF YES PLEASE DESCRIBE:_____

_____

14. DO YOU HAVE ANY ARTIFICIAL JOINTS? ☐ YES ☐ NO _____

15. DO YOU HAVE A HEART VALVE IMPLANT? ☐ YES ☐ NO

16. FAMILY HISTORY: MOTHER ☐ LIVING ☐ DECEASED CAUSE OF DEATH_____
FATHER ☐ LIVING ☐ DECEASED CAUSE OF DEATH_____
BROTHER(S) # LIVING_____ # DECEASED_____ CAUSE OF DEATH_____
SISTER(S) # LIVING_____ # DECEASED_____ CAUSE OF DEATH_____

17. IS THERE FAMILY, (BLOOD RELATIVE), HISTORY OF THE FOLLOWING:

☐ ARTHRITIS	☐ BUNIONS	☐ DIABETES	☐ HAMMER TOES	☐ NEUROLOGICAL DISORDER	☐ NONE
☐ BLEEDING DISORDER	☐ CIRCULATION PROBLEM	☐ FLATFEET	☐ HEART DISEASE	☐ STROKE	

18. SOCIAL HISTORY: DO YOU SMOKE? ☐ NO ☐ 1/2 PACK PER DAY ☐ 1 PACK PER DAY ☐ 1 1/2 PACKS PER DAY ☐ 2 PACKS PER DAY ☐ NEVER SMOKED
ARE YOU A FORMER SMOKER ☐ NO ☐ YES IF YES WHEN DID YOU QUIT SMOKING?_____
DO YOU DRINK? ☐ NO ☐ SOCIALLY ☐ 1 DRINK PER DAY ☐ 2 DRINKS PER DAY ☐ MORE THAN 2 DRINKS PER DAY

PLEASE CHECK THE PHONE NUMBER(S) WHERE WE MAY CONTACT YOU OR LEAVE A MESSAGE FOR YOU:

☐ HOME# (_____) _____ ☐ WORK# (_____) _____ EXT:_____ ☐ CELL# (_____) _____

MAY WE E-MAIL INFORMATION TO YOU? □ NO □ Yes Email address_____
MAY WE TEXT INFORMATION TO YOU? □ NO □ Yes

I authorize Northwest Podiatry Center to release medical information to:_____
Relationship: ☐ Spouse ☐ mother ☐ father ☐other_____

PATIENT SIGNATURE:_____ DATE:_____

GUARDIAN SIGNATURE:_____ RELATIONSHIP: ☐ MOTHER ☐ FATHER ☐ OTHER _____
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