Today's Date / /

Patient Background

Name ____________________ Birthdate ___/___/_____ Age__________

Address ____
Number & Street City State Zip code

Home phone______________ Cell phone ______________ Work phone ______________

UW Medical record number (if you have one) ______________ Social Security # _____-______-______

Preferred Language __________ Race __________ Ethnicity __________ ☐ Decline to answer

Student ☐ Employed by ______________ Email ______________________
(For office use only. We will not provide your email address to any other person or institution for any reason)

In emergency please call ____________________ Relationship __________ Tel. __________

I was referred to this office by: ☐ Physician/nurse ______________ ☐ Friend ______________
☐ Yellow Pages ☐ Internet ☐ Insurance Co.

Primary physician: Name, address, tel. # ______________________________

Are you now under the care of a doctor? ☐ Yes ☐ No. For what condition(s)? ______________________

____

Current medications (include dosage) ______________________________

____

Which pharmacy do you use most often? ______________________________

Please check the box next to any condition you have had:

☐ Diabetes	☐ Tuberculosis	☐ Arthritis	☐ HIV
☐ High blood pressure	☐ Hives	☐ Gout	☐ MRSA
☐ Heart disease	☐ Asthma	☐ Epilepsy	☐ Other ______________
☐ Stomach ulcers	☐ Hay fever	☐ Anemia	
☐ Kidney disease	☐ Skin disorder	☐ Bleeding tendencies	______________
☐ Liver disease	☐ Tumors (benign)	☐ Difficulty healing when cut	
☐ Glaucoma	☐ Cancer ______________ Of what?	☐ Hepatitis	______________

Are you allergic or have you had an adverse reaction to any of the following? <u>If yes, please indicate the reaction</u> e.g. rash, itching, difficulty breathing or GI upset.

☐ **No drug allergies**	☐ Latex	☐ Cortisone	☐ Other__________
☐ Penicillin	☐ Adhesive tape	☐ Demerol	
☐ Other antibiotic __________	☐ Codeine	☐ Sulfa	______________
☐ Aspirin	☐ Iodine		
☐ Local anesthetic			

Please describe your current foot problem (why are you here today?): ______________________

____

Have you regularly smoked? ☐ **Yes** ☐ **No**

If yes ☐ Cigarettes ☐ Pipe ☐ Cigars For how many years?_______ Number per day_______ Quit date _________

List any previous surgical procedures ____

Have you had previous care by a Podiatrist? ☐ Yes ☐ No. If yes, for what and when was your last visit? ____________

____

	Yes	No	
Do you often have sensations of numbness or tingling in your feet?	☐	☐	
Do you experience foot or leg cramps when walking?	☐	☐	
Have you ever broken any bones in your feet or ankles?	☐	☐	If yes, which bones and when? _________

____

Have you had any foot infection in the past two years?	☐	☐	
Have you ever had foot surgery?	☐	☐	If yes, what was done? _______________

____

What is your shoe size? ___________ Narrow/Medium/Wide and is it Mens/Womens? (Please circle)

Financial Information

Other than insurance, who is responsible for the bill? ☐ I am ☐ Parent ☐ Other ______________________________

Name & address of responsible party if other than yourself: _______________________ Telephone: ______________

____

____

Primary Insurance ___________________________Subscriber # __________ _______ Group # ________________

Address ____ Phone Number:__________________________

Secondary Insurance ___________________________Subscriber # __________ _______ Group # ______________

Insured's (Policy Holder's) name _________________________ _____/____/_____ Relationship ________________
Policy holder's birth date

As a courtesy we will file your insurance claim for you. Your insurance may cover some or all of the costs of your treatment. Please remember that although we will assist you with your claim, you are financially responsible for charges not fully covered by your insurance. If your insurance carrier does not respond to your claim within 45 days, you will be requested to make payments for the services you have received.

If you have any questions regarding the cost of your care, please ask.

HMO & PPO members: If your insurance requires a written, approved referral it is your responsibility to obtain that referral. If you do not have a valid referral at the time of your visit, you will be held financially responsible for the full costs of your treatment.

I understand that my signature requests that insurance payment be made directly to the treating physician. I also authorize the release of medical information necessary to pay the claim.

I have read and understood the above.

Signature____