

Advanced Ankle and Foot Centers

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PATIENT INFORMATION

Social Security # _____ Date: _____

Home # _____ Cell # _____

Patient: _____
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL) (AGE) (BIRTHDATE)

Sex (M or F): _____ Single__ Married__ Widowed __ Divorced __

Address: _____

(CITY)

(STATE)

(ZIP CODE)

(SPOUSE/GUARDIAN)

(NEAREST RELATIVE NOT LIVING WITH YOU & PHONE#)

Has Any Member Of Your Family Been To Our Office : YES _____ NO _____

IF YES: Name and Relation _____

Place of Employment: _____

Phone # _____

Medical Insurance Company Name and Address: *(Please present insurance card to receptionist)*

Primary Insured's: _____
(NAME) (Date of Birth) (SOCIAL SECURITY)

(INSURANCE COMPANY NAME)

(POLICY#)

(GROUP #)

How will you be paying for your services today? __ Cash __ Check __ Charge Card

Name of Family Doctor: _____

Whom may we thank for referring you to our office: _____

I give permission to Advanced Ankle and Foot Centers, LLC to release any information requested by my insurance company and give Advanced Ankle and Foot Centers, LLC permission to perform general procedures in the diagnosis and/or treatment of my condition. I authorize payment of medical benefits to Advanced Ankle and Foot Center, LLC for services provided.

Patient/Guardian Signature: _____ Date: _____

Please ask our staff to help you with this form if you would like assistance.

What is your foot or ankle concern? _____

How have you treated this problem at home? _____

Have you injured your feet before, and if so, how? _____

What type of work do you do? _____

You're Height _____ Weight _____ Shoe Size/Width _____

Have you had foot treatment before? (Please list) _____

List any prior surgeries (& dates) of your foot and/or ankle _____

Have you had any other type of surgery? (Please list) _____

Any complications with surgery or anesthesia? _____

What medication are you now taking? _____

Pharmacy Name & Location _____

Do you: Smoke? (amount and years) _____ Drink alcohol?(Amount/years) _____

Have any history of illicit drug use? _____ Are you pregnant? Yes No

I am not allergic to anything to my knowledge

I am allergic to (list reaction also): _____

Please check appropriate places. I have or have had the following:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Arthritis/Rheumatism	<input type="checkbox"/> Deep Vein Thrombosis/bloodclot	<input type="checkbox"/> Hypothyroidism
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Leg Cramps
<input type="checkbox"/> Bladder Problems	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Murmur
<input type="checkbox"/> Bleeding Tendencies	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Cancer	<input type="checkbox"/> gout	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cardiac/heart disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Chronic Kidney Disease	<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Other _____		

Please check appropriate places. I have recently had the following:

_____ Abdominal pain _____ chest pain _____ joint pain
_____ Bleeding problems _____ Fever/vomiting/nausea _____ Psychiatric/emotional difficulty
_____ Breathing/respiratory problems _____ Hypertrophic/abnormal scars _____ Rash
_____ Burning numbness _____ Injury opened skin/sores _____ Urinary difficulty/pain

Please check appropriate places. If a family member has or had any of the following:

	Mother	Father	Siblings
Anemia	_____	_____	_____
Arthritis	_____	_____	_____
Asthma	_____	_____	_____
Bleeding Problems	_____	_____	_____
Blood Clots/DVT	_____	_____	_____
Cancer	_____	_____	_____
Cardiac Disease	_____	_____	_____
Diabetes	_____	_____	_____
Glaucoma	_____	_____	_____
Gout	_____	_____	_____
Heart Murmur	_____	_____	_____
Hepatitis	_____	_____	_____
High blood pressure	_____	_____	_____
HIV	_____	_____	_____
Kidney trouble	_____	_____	_____
Nervousness	_____	_____	_____
Pace Maker	_____	_____	_____
Peripheral Vascular Disease	_____	_____	_____
Ulcers	_____	_____	_____