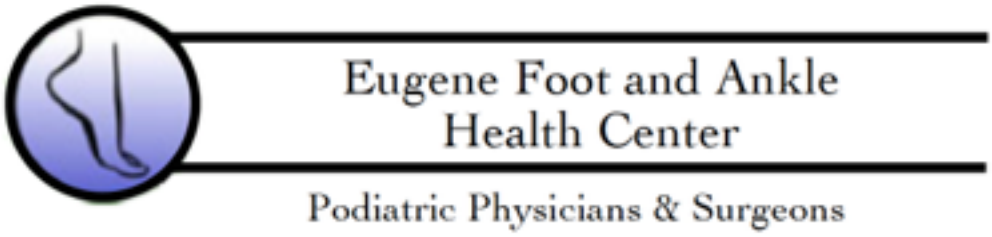

Patient Information

Date_____
Name_____
Address_____
City_____ State_____ Zip_____
Home Phone_____
Cell Phone_____
Work Phone _____
E-mail_____
Male / Female Age_____ DOB_____
Employer_____
Occupation_____
Family Doctor_____
Pharmacy_____

☐ Married ☐ Widowed ☐ Single
☐ Separated ☐ Divorced ☐ Partner

In Case of Emergency, Contact:
Name_____
Relationship_____
Phone Number_____

How did you first hear about Eugene Foot and Ankle?

_____

Treatment Consent

I hereby consent and give permission to the doctor (and the doctor's assistant or designated replacement) to evaluate me as the doctor deems necessary.

_____
Signature of Beneficiary, Guardian, Or Representative

_____
Print Name

_____
Date

Primary Insurance

Subscriber's Name_____
Subscriber's DOB_____
Relationship to Patient_____
Insurance Co:_____

Secondary Insurance

Subscriber's Name_____
Subscriber's DOB_____
Relationship to Patient_____
Insurance Co:_____

Insurance Assignment and Release

I certify that I have insurance coverage and assign Eugene Foot and Ankle all insurance benefits if any otherwise payable to me for the services provided. I understand that I am financially responsible for all charges including the cost of Collection Agency fees, whether my insurance company pays or not.

I hereby authorize Eugene Foot and Ankle to release all necessary information to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____
Signature of Beneficiary, Guardian, Or Representative

Medicare/Medigap Authorization

I request that payment of authorized Medicare/Medigap benefits, be made either to me or on my behalf to Eugene Foot and Ankle for any services furnished to me by the provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid services my Medigap Insurer, and their agents any information needed to determine these benefits or benefits fore related services

_____
Signature of Beneficiary, Guardian, Or Representative

Podiatric History

What is the **chief complaint** for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints)

_____

_____

Athletic activities in which you participate?

What?_____

How Often?_____

Please indicate which foot problems you have:

- ☐ Ankle Pain
- ☐ Athlete's Foot
- ☐ Bunions
- ☐ Corns/Calluses
- ☐ Fungal Nails
- ☐ Numbness in Feet/Legs
- ☐ Flat Feet
- ☐ Foot or Leg Cramps
- ☐ Heel Pain
- ☐ Ingrown Toenails
- ☐ Plantar Warts
- ☐ Swelling in Ankles/Feet
- ☐ Tired Feet

Height_____ Weight_____

Do you take Birth Control? Yes / No

Have you ever been to a podiatrist before? Yes / No

If yes please list:

Name_____

Last Visit_____

If you are Diabetic, what was your last:

AM Blood Sugar_____ HgA1c_____

Review of Systems

Please circle all that apply:

1) Heart burn / hepatitis / nausea / vomiting blood in stool / liver disease
2) Thyroid disease / heat or cold intolerance
3) Weight loss / loss of appetite
4) Blurred vision / double vision / vision loss
5) Hearing loss / hoarseness / trouble swallowing
6) Chest pain / palpitations
7) Chronic cough / shortness of breath
8) Painful urination / blood in urine / kidney problems / dialysis
9) Frequent rashes / skin ulcers / psoriasis / lumps
10) Headaches / dizziness / seizures
11) Sleep disorder / depression / drug/alcohol addiction
12) Easy bleeding or bruising / anemia
13) **None of the above**
14) **HIV positive? Yes / No Hepatitis C positive? Yes / No**
15) **MRSA? Yes / No Year** _____

Your Past Medical History

Please circle all that apply:

Anemia	Fibromyalgia
Gout	Chronic Back Pain
Cancer	Bleeding Disorder
Diabetes	Heart Condition
Seizures	Irregular Heart Beat
Stroke	Heart Attack
AIDS	Asthma/Emphysema
Rheumatoid Arthritis	Pulmonary Embolism
Stomach Ulcers	Blood Clots
Osteoarthritis	Sleep Apnea
High Blood Pressure	Kidney Transplant
High Cholesterol	Thyroid Disease

Other_____

List any surgical procedures with year performed starting with the most recent _____

_____

Have you ever had issues with anesthesia? If so, explain_____

Do you smoke? Yes / No

How much?_____

For how long?_____

Do you drink alcohol? Yes / No

How much?_____

Do you use any of the following (circle)?

Cane / Walker / Wheelchair / Brace

Is there any **Family History** of:

- ☐ DVT/Blood Clot Who?_____
- ☐ Diabetes
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ CAD
- ☐ Heart Attack
- ☐ Stroke
- ☐ Other_____ _____

Allergies? Yes / No Please list: _____

Current Medications: Please provide a medication list from your primary care provider.

1. _____ 2. _____ 3. _____

Are you currently taking any anticoagulants? Yes / No (circle)

Warfarin Coumadin Xarelto Aspirin Eliquis Heparin Plavix Pradaxa

Pain Contract? Yes / No Pain Doctor: _____