

FOOT AND ANKLE OF THE CAROLINAS

Patient Information

Patient Name _____ Sex: ___ M ___ F **Age _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell _____
E-Mail Address _____
Social Security # _____ Date of Birth _____
Employer _____ Occupation _____
Shoe Size _____ Marital Status _____
Reason for visit: _____

Primary Care Doctor _____ Date last seen _____
Doctors address _____ Phone _____
Who referred you to us? _____

Medical History: (please check any condition you have or have had in the past)

___ AIDS (HIV) ___ Arthritis ___ Rheumatic Fever ___ Allergies
___ Blood Clots ___ Diabetes ___ High Blood Pressure ___ Ulcers
___ Heart Condition ___ Hepatitis ___ Liver Condition ___ Keloids
___ Kidney Disease ___ Phlebitis ___ Poor Circulation ___ Asthma

Past Surgical History:

Surgery _____ Date _____ Surgery _____ Date _____
Have you had previous care from another podiatrist? Who? _____ When? _____
Medications you are currently taking: _____

DRUG ALLERGIES:

Are you allergic to: ___ Anesthesia ___ Tape ___ Latex ___ Other?
Do you Smoke? ___ If yes, how much? ___ Do you drink? ___ If yes, how much? ___
Have you experienced any of the following in the last week?
___ Chest Pain ___ Shortness of breath ___ Calf or Leg Pain
___ Back Pain ___ Numbness in legs or Feet ___ Blurred Vision

INSURANCE INFORMATION:

Primary Insurance Company: _____ Policy ID# _____
Insured (Policy Holder): _____ Date of Birth: _____
Relationship to patient: _____

Secondary Insurance Company: _____ Policy ID#: _____
Insured (policy Holder) _____ Date of Birth: _____
Relationship to patient: _____

**I understand that I am financially responsible for charges not covered by my insurance.

**I authorize the release of any medical information needed to process my claims.

Signature: _____ Date: _____

**I was provided a copy of the Notice of Privacy Practices, and that I have read (or had the opportunity to read, if I so choose) and I understand the Notice.

Signature: _____ Date: _____