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# WELCOME TO PREFERRED FOOTCARE SPECIALISTS

NAME: \_\_\_\_\_ DOB: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
FIRST MI LAST

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ MARITAL STATUS: single married separated divorced widowed  
(PLEASE CIRCLE)

ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ CELL #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ WORK #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

NAME OF EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_ Can we use?: YES NO  
(We will not give your e-mail address out to anyone, for any reason. We will only send important information to you)

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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**INSURANCE INFORMATION**

(If your condition is due to an accident or injury from work, auto, or third party, please see Staff.)

PRIMARY INSURANCE: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_ COPY: \_\_\_\_\_  
For staff:

SECONDARY INSURANCE: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_ COPY: \_\_\_\_\_

NAME OF INSURED'S EMPLOYER: \_\_\_\_\_ GUARANTOR: \_\_\_\_\_

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**AUTHORIZATION**

I understand that there may be times when Preferred Footcare may need to contact me.

**I give Preferred Footcare staff permission to contact me:**

At home  Cell phone  At work

**I give Preferred Footcare staff permission to leave messages on:**

My home answering machine  My work answering machine  My cell phone voicemail

**I give Preferred Footcare staff permission to leave messages with:** \_\_\_\_\_

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**AUTHORIZATION OF MEDICAL RELEASE**

I authorize Preferred Footcare Specialists to release:

- Information to specialists that I have been referred to in order to provide proper care.
- Information to any hospital, physician, or nurse practitioner that may be participating in my care.
- Information on my care to my insurance company.
- Information regarding my care to help obtain required pre-certifications as well as insurance payments.

**I understand that if my decision to release medical records changes, that it is my responsibility to inform Preferred Footcare Specialists. I also understand that Preferred Footcare Specialists will use current HIPPA standards to release these records.**

Signature: \_\_\_\_\_

Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**REVIEW OF SYSTEMS**

**HEIGHT:** \_\_\_\_\_

**WEIGHT:** \_\_\_\_\_

**SHOE SIZE:** \_\_\_\_\_

**FAMILY PHYSICIAN:** \_\_\_\_\_

**LAST SEEN:** \_\_\_\_\_

**Have you ever seen a Podiatrist?** (If so, by whom and for what type of treatment): \_\_\_\_\_

**Have you ever had a problem with Anesthesia?**  Yes  No **If yes, please explain:** \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**MEDICATIONS:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please check any of the following that pertains to you.**

**Constitutional:**

- Weight loss
- Weight gain
- Fatigue
- Night sweats
- Weakness
- Chills
- Headaches

**Respiratory:**

- Difficulty breathing
- Cough
- History of Pneumonia
- Smoker Packs/day: \_\_\_\_\_
- TB exposure
- Lung or breathing problems

**Endocrine:**

- Diabetes Type: \_\_\_\_\_
- Heat intolerance
- Cold intolerance
- Eat a lot
- Drink a lot
- Urinate a lot

**Ears:**

- Hearing loss
- Ringing in the ears
- Dizziness

**Eyes:**

- Glasses
- Blurred vision
- Pain/Dry/Red/Watery

**Nose:**

- Congestion
- Sinus problems
- Bleeding
- Sneezing

**Throat:**

- Pain
- Difficulty swallowing
- Hoarseness

**Cardiac:**

- Chest pain
- Murmurs
- Peripheral Edema
- Claudication
- Bleeding problems
- Blood transfusion
- Heart problems Type: \_\_\_\_\_
- Hypertension
- Phlebitis
- Poor circulation
- Stroke Type: \_\_\_\_\_

**Gastrointestinal:**

- Indigestion
- Reflux
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Abdominal pain
- Heartburn
- Liver problems
- Stomach ulcer
- Hepatitis exposure

**Musculoskeletal:**

- Joint pain
- Joint swelling
- Swelling in feet or legs
- Trauma
- Trauma to feet or legs
- Muscle aches
- Muscle weakness
- Tremors
- Back pain
- Cramping of feet or legs
- Gout

**Genitourinary:**

- Frequent urination
- Urgency of urination
- Blood in the urine
- Kidney problems

**Blood/Lymph:**

- Anemia
- Easy bleeding
- Easy bruising
- Swollen glands

**Immune:**

- Cancer
- Infectious/contagious disease
- Poor healing

**Neuro/Psych:**

- Seizures
- Passing out
- Coordination problems
- Depression
- Anxiety
- Insomnia

**Surgeries:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**FAMILY MEDICAL HISTORY:**

**ILLNESS/DISEASE**

**IF DECEASED/CAUSE OF DEATH**

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Siblings: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Children: \_\_\_\_\_  
\_\_\_\_\_

**PATIENT SOCIAL HISTORY:**

Use of alcohol: Never \_\_\_\_\_ Rarely \_\_\_\_\_ Moderate \_\_\_\_\_ Daily \_\_\_\_\_ Amount \_\_\_\_\_

Use of tobacco: Never \_\_\_\_\_ Previously, but quit \_\_\_\_\_ weeks/months/years ago Current pack/day \_\_\_\_\_

Use of drugs: Never \_\_\_\_\_ Type/Frequency \_\_\_\_\_

History of addiction to prescription or non-prescription drugs: Never \_\_\_\_\_ Type \_\_\_\_\_

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**HEALTH INFORMATION PRIVACY PRACTICES ACT**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

**SIGNATURE:** \_\_\_\_\_ **DATE:** - -

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**FINANCIAL AGREEMENT**

I have received the Financial Policy and I have been provided the opportunity to review it.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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