

We are very pleased to have you with us. Please fill in all the appropriate blanks below. This information is important for your health and our records. If you need help, do not hesitate to ask. PLEASE PRINT.

Date \_\_\_\_\_ Email Address \_\_\_\_\_

Patient's Name \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Social Security # \_\_\_\_\_ Marital Status \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Social Security # \_\_\_\_\_

Is this a Worker's Compensation Claim?  Yes  No

PRIMARY INSURANCE		SECONDARY INSURANCE	
Employer:		Employer:	
City:	Bus. Telephone:	City:	Bus. Telephone:
Insurance Company:		Insurance Company:	
Birthdate of Subscriber:	SSN:	Birthdate of Subscriber:	SSN:
Subscriber's Name (If not same)	Relation:	Subscriber's Name (If not same)	Relation:

<p><b>PODIATRIC HISTORY</b></p> <p>Please indicate which foot problems you now have or have had in the past.</p> <p>Ankle Pain <input type="radio"/> Yes <input type="radio"/> No</p> <p>Athlete's Foot <input type="radio"/> Yes <input type="radio"/> No</p> <p>Bunions <input type="radio"/> Yes <input type="radio"/> No</p> <p>Corns and Calluses <input type="radio"/> Yes <input type="radio"/> No</p> <p>Cramps or Numbness in Feet or Legs <input type="radio"/> Yes <input type="radio"/> No</p> <p>Flat Feet <input type="radio"/> Yes <input type="radio"/> No</p> <p>What is your present foot problem? _____</p>		<p>Cigarette/Tobacco use _____</p> <p>Years smoked _____</p> <p>Foot or Leg Cramps <input type="radio"/> Yes <input type="radio"/> No</p> <p>Heel Pain <input type="radio"/> Yes <input type="radio"/> No</p> <p>Ingrown Toenails <input type="radio"/> Yes <input type="radio"/> No</p> <p>Plantar Warts <input type="radio"/> Yes <input type="radio"/> No</p> <p>Swelling in Ankles or Feet <input type="radio"/> Yes <input type="radio"/> No</p> <p>Tired Feet <input type="radio"/> Yes <input type="radio"/> No</p>	<p>Is there any personal or family history of diabetes?  <input type="radio"/> Yes <input type="radio"/> No</p> <p>If yes (you), do you take pills or insulin for your condition? <input type="radio"/> Pills <input type="radio"/> Insulin</p> <p>Athletic activities in which you participate (please list and indicate frequency)</p> <p>_____</p> <p>_____</p>
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**PLEASE COMPLETE ALL SECTIONS ON THE BACK OF THIS FORM. THANK YOU!**

Family Doctor or Internist \_\_\_\_\_ Who Referred You to Our Office? \_\_\_\_\_

Please name the pharmacy you prefer \_\_\_\_\_

Has this office seen or treated any member of your family?  Yes  No

If yes, whom? Name \_\_\_\_\_ Relationship \_\_\_\_\_

Nearest relative and address (not living with you) \_\_\_\_\_

How did you hear about this office? \_\_\_\_\_

*I hereby give my permission to NE Ohio Foot, Ankle & Wound Center Inc. to examine, photograph, administer treatment, and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot problem.*

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

Parent's Signature (If Minor): \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS**

I understand my signature authorizes the release of all information necessary to secure the payment of benefits from my insurance or agency. I hereby authorize Medicare, Medicaid, and/or the \_\_\_\_\_ Insurance Company to pay **NE Ohio Foot, Ankle & Wound Center Inc.** the medical and surgical benefits allowable and otherwise payable under my Insurance Policy. I understand I am financially responsible to **NE Ohio Foot, Ankle & Wound Center Inc.** for charges not covered by this assignment.

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

# ABOUT MY HEALTH

**LIST MEDICATIONS CURRENTLY TAKING:** Including prescriptions, over-the-counter medications and vitamins


**LIST ALLERGIES:**

Any other Allergies

- |   |   |
|---|---|
| <input type="radio"/> Adhesive/Tape         | <input type="radio"/> Local Anesthetics |
| <input type="radio"/> Anticoagulant Therapy | <input type="radio"/> Novocaine         |
| <input type="radio"/> Aspirin               | <input type="radio"/> Penicillin        |
| <input type="radio"/> Codeine               | <input type="radio"/> Seafoods          |
| <input type="radio"/> Demerol               | <input type="radio"/> Sulfa             |
| <input type="radio"/> Iodine                | <input type="radio"/> None              |


**LIST SERIOUS ILLNESSES:**


**LIST PREVIOUS OPERATIONS:**

(Surgery)	(Date)	(Surgery)	(Date)
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Hospitalization other than for the surgeries listed:

**GENERAL MEDICAL HISTORY** Place a mark on "Yes" or "No" to indicate if you have had any of the following:

<p>AIDS/HIV ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Allergies to Anesthetics ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Allergies to Medicine or Drugs ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Anemia ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Angina ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Arthritis ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Artificial Heart Valves or Joints ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Asthma ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Back Problems ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Bleeding Disorders ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Chemical Dependency ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Circulatory Problems ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Diabetes ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Epilepsy ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Fainting ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Foot or Leg Cramps ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Gout ..... <input type="radio"/> Yes <input type="radio"/> No</p>	<p>Heart Disease ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Hemophilia ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Hepatitis or Jaundice ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>High Blood Pressure ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Kidney Problems ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Liver Disease ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Phlebitis ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Psychiatric Care ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Rash ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Rheumatic Fever ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Shortness of Breath ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Stroke ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Swelling in Ankles and Feet ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Tired Feet ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Ulcers ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Varicose Veins ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Venereal Disease ..... <input type="radio"/> Yes <input type="radio"/> No</p> <p>Unexplained Weight Loss ..... <input type="radio"/> Yes <input type="radio"/> No</p>	<p>Are you now, or have been under any other doctor's care for any reason over the past two years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please explain: _____</p> <p>_____</p> <p>Any Comments/Concerns:</p> <p>_____</p> <p>In case of EMERGENCY, please notify:</p> <p>_____</p> <p style="text-align: center;">Relationship</p> <p>Phone Number: _____</p> <p>or: _____</p>
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