PATIENT INFORMATION

Patient's Last Name	First			Middle Initial
Street Address / City	State	Zip Code	Home Phone	
Cell Phone	Date of Birth	□ Male □ Female	Social Security Number	Marital Status □ Single □ Married □ Divorced □ Widowed
Patient's Occupation	Patient's Employer	Emergency Contact Name	Emergency Phone Number	
Employer Street Address	City	State	Zip Code	Work Phone

What type of Insurance do you have?

□ Medicare □ Medicaid □ BC/BS □ Aetna □ Cash Pay □ Other:

Policy Number	Group Number		
Is Policy Holder the patient? □ Yes □ No	If not, Name of Policy Holder?	Date of Birth Policy Holder	Relationship □ Spouse □ Parent □ Other
Policy Holder Social Security Number	□ Male □ Female	Patient Email Address	

HOW DID YOU HEAR ABOUT US?

□ Google □ Yahoo □ Ins. List

□ Bing □ Facebook □ Other

□ Doctor's Office/Clinic:

□ Family/Friend:

MEDICAL HISTORY

Family Doctor:		Date Last Seen:	Pharmacy:
Shoe size:	Height:	Weight:	Smoke? □ No □ Yes: ____ packs/day □ Ex-Smoker quit ____ years ago

Vaccines Flu □ No □ Yes when? _____ Pneumonia □ No □ Yes when? _____ Alcohol? □ No □ Yes: ____ per ____

Family Medical History □ Heart Disease □ High Blood Pressure □ Diabetes □ Cancer □ Cholesterol

Your Medical History

Diabetes:
□ Insulin
□ Non-insulin

□ Last blood glucose: ____
□ Last Hg A1c: ____
□ When? ____
□ High Blood Pressure
□ Heart Disease
□ Asthma
□ Bleeding Problems
□ Kidney Disease
□ Gout
□ Nerve Pain Pacemaker
□ Anemia
□ Anxiety
□ Depression
□ Osteoporosis
□ Cancer
□ Liver Disease
□ HIV
□ Cholesterol UTI
□ Seizures
□ Osteoarthritis
□ Rheumatoid Arthritis
□ Blood Clots
□ Other:

In the last 6 months?

□ Weight loss
□ Appetite change
□ Leg cramps
□ Blurred vision
□ Headache
□ Cough
□ Palpitations
□ Shortness of breath
□ Heart attack
□ Stroke
□ Rashes
□ Chest pain
□ Masses
□ Major trauma

Allergies □ None □ Penicillin □ Codeine □ Sulfa □ Iodine □ Anesthetics □ Latex □ Jewelry □ Shrimp □ Anti-inflammatories □ Other:

Penicillin Codeine Sulfa Iodine Anesthetics Latex Jewelry Shrimp Anti-inflammatories Other:

Medication Name	Dose	Medication Name	Dose	Medication Name	Dose

Are you on blood thinners or aspirin? □ No □ Yes List:

Have you had any recent falls? □ No □ Yes When/How often:

Have you had any stents or peripheral vascular surgery? □ No □ Yes When/Surgeon:

Are you pregnant or planning a pregnancy? □ No □ Yes Explain:

Surgical History - Please list any surgeries you have had, include dates and surgeon's name if possible

Name of Procedure	Date	Surgeon

Do you have any surgeries planned/pending? ☐ No ☐ Yes Details:

Current Foot Problems:

Mark drawings below with numbers 1 and 2 to identify problems

LEFT RIGHT

Describe up to 2 main problems in greater detail below

1. Describe your problem and it's cause if you know:
My first problem is: ☐ Left foot ☐ Right foot ☐ Both feet

____
____
____
____

Is this problem work related: ☐ No ☐ Yes Date: ____________________

My pain/discomfort began: ________________________________

Pain Scale: (circle) 1 2 3 4 5 6 7 8 9 10
Minimal Moderate Severe Intolerable

It occurs when: ____

Previous medical treatment(s): ______________________________
____
____
____

Additional Problem

2. Describe your problem and it's cause if you know:
My first problem is: ☐ Left foot ☐ Right foot ☐ Both feet

____
____
____

Is this problem work related: ☐ No ☐ Yes Date: ____________
My pain/discomfort began: ________________________________
Pain Scale: (circle) 1 2 3 4 5 6 7 8 9 10
Minimal Moderate Severe Intolerable
It occurs when: ____
Previous medical treatment(s): ______________________________
____
____
____

*Medical Infromation Release Form (HIPPA Release)

☐ I acknowledge receiving a copy of the ETFA Notice of Privacy Practices and I hereby authorize the release of information including diagnosis, records, claims and examination rendered to me. This information may be released to:

☐ Spouse: ________________________________

☐ Child(ren): ______________________________

☐ Other: _________________________________

☐ Information is not to be released to anyone.

* This Release of information will remain in effect until terminated by me in writing.

Messages

Please Call: ☐ my work ☐ my home
☐ my cell number: ____________________

if unable to reach me:

☐ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ Other: ___________________________________

I authorize the release of any medical information necessary to process this claim and request payment of benefits, government or other, be made to: ETFA

I hereby give permission to the podiatrists of ETFA to examine, treat and perform such procedures as may be necessary for the treatment of my condition.

Signed: ___________________________________

Witness: ________________________ Date: ________