PERSONAL HEALTH INFORMATION

Briefly describe your foot problem(s): ______________________________

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Please check all of the following that YOU currently have or have ever had:

	YES	NO
Diabetes		
Heart Disease		
High Blood Pressure		
Stroke		
Glaucoma		
Kidney Disease		
Bleeding Problems		

	YES	NO
Anemia		
Phlebitis		
Hepatitis		
Asthma		
AIDS/HIV		
GI Ulcer		
Cancer		

	YES	NO
Rheumatic Fever		
Rheumatoid Arthritis		
Gout		
Epilepsy		
Thyroid Problems		
Liver Disease		
Heart Murmur		

Other: ______________________________

List Current Medications (If you have a list we will copy it for your record): ____________

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Pharmacies that you use: ______________________________

Allergies to: Medications: ______________________________
Latex: Y / N Tape: Y / N Contrast Dye: Y / N

Please check all of the following that apply:

Smoke? Y / N How many packs per day? ____ How many years? ____

Drink? Y / N How many drinks per day? ____ How many years? ____

Drug use? Y / N If yes, what type? ______________________________

Past Surgeries and Hospitalizations:______________________________

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Family History:	YES	NO
Diabetes		
High Blood Pressure		
Heart Disease		
Circulation Problems		

Employment: Sit at job? Y / N Stand at job? Y / N Stand and walk at job? Y / N

PATIENT NAME: ____

Last First Initial

Street Address: ____

City: ______________________ State: __________________Zip: ______________

Home Phone: __________________ Cell Phone: ________________

Would you like access to your personal health record online? Y / N

If yes, please provide email address:____

Marital Status: _________________ Age: ________Birthday: _____________ Sex: M / F

Height: ______________________ Weight: __________________Shoe Size: __________

EMPLOYER: ________________________Occupation:__________________________

Business Address: ______________________Business Phone: ______________________

EMERGENCY CONTACT NAME:____

Relationship: _________________________Phone number: ________________________

May we talk to this person regarding your medical concerns if we cannot reach you? Y / N

May we leave a message at your home or cell phone regarding appointments? Y / N

PRIMARY CARE DOCTOR: _________________________ Date Last Seen: ___________

Whom may we thank for referring you? ____

PRIMARY INSURANCE: ____

ADDITIONAL INSURANCE: ____

AGREEMENT AND RELEASE:
I, the undersigned, certify that I (or my dependent) have current insurance coverage with the above carriers and assign directly to South County Foot & Ankle, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize South County Foot & Ankle, Inc. to administer such treatments and perform such procedures necessary or advisable in the diagnosis and treatment of the undersigned or designated patient. I have received my HIPAA Privacy Policy and understand my rights.

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Responsible Party Signature Relationship Date