Name: _____

Date of Birth|Age: ___/___/___|___

Mailing Address: _____

_____

(Check Preferred contact Method)

☐ Home Phone: _____

☐ Work Phone: _____

☐ Cell Phone: _____

☐ Email: _____

Primary Care Dr. _____

Date last seen: ___/___/___

Preferred Pharmacy: _____

Phone: _____

Primary Insurance: _____

Policy# _____

Name on Policy: _____

Secondary Insurance: _____

Policy # _____

Name on Policy: _____

Emergency Contact:

Name: _____

Relationship: _____

Address: _____

_____

Phone: _____

Pro Active Podiatry

Foot & Ankle Specialists

Is this visit for a Work related Injury? ☐ Yes ☐ No

Occupation: _____

Employer: _____

Point of Contact: _____

Address: _____

_____

Phone: _____

_____

How did you hear about our Office?

☐ Friend/Family

☐ Other Doctor

☐ Our Website

☐ Insurance

☐ Other:

Who can we thank for your visit?

_____

If you would like Pro Active Podiatry to file your insurance claim please provide your insurance card(s) along with a photo ID. Without your card your claim can not be filed. Payment is due in full at the time you are seen, unless other arrangements have been made with us.

By signing below I am authorizing Pro Active Podiatry to release all medical information necessary to process my insurance claim. I authorize payment of insurance benefits to be made to Pro Active Podiatry, unless my account is paid in full. I also understand it is my responsibility to know my insurance benefits and to ensure the following: Provider participation with my insurance policy, and obtaining all proper authorizations from Primary Care Providers when necessary.

X _____

Signature Date

Notice of Privacy Policies

I acknowledge I was offered and/or provided a copy of the Notice of Privacy Practices and have read (or have had the opportunity to read) and understand the notice.

X _____

Signature Date

Name: DOB:

☐ Male ☐ Female Height: Weight:

Pro Active Podiatry
Foot & Ankle Specialists

Allergies:
☐ None
☐ PCN
☐ Sulfa
☐ Codeine
☐ Iodine
☐ Other

Medications:
☐ See List

Past Medical History
Do you have?
☐Diabetes
☐High Blood Pressure
☐Coronary Artery Disease
☐Congestive Heart Failure
☐Circulation Disorders
☐Stroke
☐Asthma
☐Emphysema
☐Renal Failure
☐Kidney Disorders
☐Thyroid
☐Tuberculosis
☐Cancer
☐Hepatitis
☐Liver Disorders
☐Arthritis
☐Osteoarthritis
☐Gout
☐Other

Family History
Does your family have?
☐Diabetes
☐High Blood Pressure
☐Heart Attack
☐Circulation Disorders
☐Stroke
☐Kidney Disease
☐Thyroid Disease
☐Cancer
☐Liver Disease
☐Arthritis
☐Gout
☐Other

Past Surgical History:
☐None
☐Hip
☐Knee
☐Ankle
☐Foot
☐Bunion

☐Back
☐Rotator Cuff
☐Eye

☐Hysterectomy
☐Cholecystectomy
☐Appendectomy
☐Tonsilectomy
☐Heart Bypass
☐Other

☐Artificial Joints
☐Anesthesia Complications?

Social History:
☐Single ☐Married ☐Divorced ☐Widowed

☐ Tobacco use
☐ Alcohol use
☐ Marijuana use

Occupation:

Recreational Activities:

Usual Shoe Size: _____

Typical Shoe Type:

Please describe the problem and cause, if you know:

Please mark the location on the diagrams.

When did this problem start? _____

Describe your pain:
☐ Sharp
☐ Burning
☐ Shooting
☐ Aching
☐ Throbbing
☐ Numbness
☐ Tingling
☐ Dull

What makes the problems worse?

Any previous medical treatment or home remedies?

Is there anything else we should know?