# CENTRAL IOWA PODIATRY

Newton Foot and Ankle Clinic • Pella Foot and Ankle Clinic • The Foot Doctor of Marshalltown

**First Name:** _____ **MI**_____ **Last Name:**_____ **Sex: Male Female**

**Social Security Number:** _____ **Date of Birth:**_____

**Address:** _____ **City:** _____**State:**_____ **Zip**_____

**Home Phone:**_____ **Cell Phone:**_____

**Email:**_____ **Emergency Contact:** _____

**Family Physician:** _____ **Referring Physician:**_____

**How did you hear about us? (Please circle)** Newspaper Yellow Pages Website Friend/Family Provider_____

**If applicable, may we leave medical information on your home answering machine, voicemail, or with a family member? (For example: appointment reminders, lab results, insurance coverage etc?) Yes No**

<table>
<tr><td colspan="2">Race/Ethnicity<br>☐ American Indian/Alaska Native<br>☐ Asian<br>☐ Black/African American<br>☐ Native Hawaiian or Pacific Islander<br>☐ White<br>☐ Hispanic/Latino</td><td colspan="2">Preferred language:<br>☐ English<br>☐ Spanish<br>☐ Other_____</td></tr>
<tr><td>Employment status:<br>☐ Full time<br>☐ Part time<br>☐ Unemployed<br>☐ Retired<br>☐ Student</td><td>Employer Name:<br>_____<br>Employer Phone:<br>_____</td><td>Marital Status:<br>☐ Married<br>☐ Single<br>☐ Widowed<br>☐ Divorced<br>☐ Minor</td><td>If patient is a minor:<br>Parent/guardian's name:<br>_____<br>Parent/guardian birthdate:<br>_____</td></tr>
</table>

## Authorizations & Policies

**Responsibility of Payment:** I understand deductibles, co-pays, and co-insurance are due at the time of service, and are an estimate of charges only, and that other charges may apply. I understand that I am personally responsible for any charges incurred for services provided by Central Iowa Podiatry and/or Newton and/or Pella Foot and Ankle Clinics and/or The Foot Doctor of Marshalltown that are not covered by insurance or legal settlement. I understand I must pay these in a timely manner and that I may contact the billing department to make payment arrangements if needed. I understand my account will placed in collections if I do not pay these. If patient is a minor, responsibility of payment falls to parent or guardian. It is my responsibility to notify any changes in insurance and address.

**Cancellations/No-Shows**: Central Iowa Podiatry requires 24 hour notice of any changes to your appointment, although we do understand this is not possible in every situation. If you fail to show for 3 appointments in a row you may be discharged from our care. Please keep your appointment, even if you are starting to feel better.

**Authorization to Release Information**: I understand that my charges will be submitted to my insurance company. I hereby authorize the release of any and all information necessary in the course of my examination, treatment and/or process of a claim.

**Authorization to Pay Benefits:** I hereby authorize payment to the Newton and/or Pella Foot and Ankle Clinic and/or The Foot Doctor of Marshalltown for all surgical and /or medical benefits.

**Medicare Authorization**: I authorize the release of any medical information necessary to process the claim and request payment of Medicare benefits either to myself or to the party who accepts assignment on the Medicare billing form.

**Acknowledgment of Receipt of Notice of Privacy Practices:** I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the notice.

Signature of Patient or Legal Guardian_____ Date: _____

# Medical History

**Name:** _____ **Pharmacy:** _____

**Past Surgical History:**

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

**Allergies:**

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

**Please check all that apply:**

- ☐ AIDS/HIV
- ☐ Asthma
- ☐ Cancer
- ☐ Chronic Heart Disease
- ☐ Congestive Heart Failure
- ☐ Diabetes
- ☐ Deep Vein Thrombosis
- ☐ Gout
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Kidney Problems
- ☐ Heart Murmur
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Seizures
- ☐ Stroke
- ☐ Other _____
- ☐ Other _____

**Medications**

1. _____ 11. _____
2. _____ 12. _____
3. _____ 13. _____
4. _____ 14. _____
5. _____ 15. _____
6. _____ 16. _____
7. _____ 17. _____
8. _____ 18. _____
9. _____ 19. _____
10. _____ 20. _____

**Social History- Please circle all that apply.**

**Height:**_____
**Weight:**_____

**Alcohol consumption?** Non-Drinker Social Moderate Heavy
**Caffeine consumption?** None 1-2/day 3-5/day 6-9/day 9+/day
**Exercise Frequency?** Never Moderate Often
**Tobacco Usage?** Never Former Smoker Light Smoker Heavy Smoker Chewing Tobacco

## Review of Systems – Please circle all that apply.

**Constitutional:**
Chills
Fever
Nausea
Vomiting
Weakness
Fatigue

**Cardiovascular:**
Shortness of Breath
Chest Pain
Heart Murmur
Cold Feet
Varicose Veins

**Respiratory:**
Wheezing
Cough
Trouble Breathing

**GI:**
Reflux
Diarrhea
Constipation

**Endocrine:**
Hypothyroidism
Hyperthyroidism
Temperature Imbalance

**Hematologic:**
Anemia
Bruising
Bleeding

**Musculoskeletal:**
Back Pain
Difficulty Walking
Foot Pain
Heel Pain
Joint Redness
Leg Cramps
Muscle Tenderness
Stiffness

**Integumentary:**
Athlete's Foot
Blistering
Dermatitis
Hypertrophic Scar (Keloids)
Rash

**Neurological:**
Burning
Increased Sensitivity to Touch
Numbness
Paralysis
Tingling/Prickling Sensations
Uncontrolled Movements

**Allergies:**
Runny Nose
Itchy Skin
Hives

**Family History – Check all that apply & circle affected relative (Mother, Father, Brother, Sister)**

- ☐ Cancer M F B S
- ☐ Heart Disease M F B S
- ☐ Diabetes M F B S
- ☐ Kidney Failure M F B S
- ☐ Heart Attack M F B S
- ☐ High Cholesterol M F B S
- ☐ Hypertension M F B S
- ☐ Stroke M F B S
- ☐ Other _____ M F B S
- ☐ Other_____ M F B S

Chief Complaint:_____

_____

_____

Duration of symptoms:_____

Attempted treatments: _____

_____

History of injury or trauma to the area: _____

_____

_____

**On the diagram below, please indicate where you are experiencing pain or other symptoms. Use the following to describe your symptoms:**

**A= Achy  B = Burning  N= Numbness  P= Pins & Needles  S= Stabbing  O=Other**