Central Iowa Podiatry

Newton Foot & Ankle Clinic – The Foot Doctor of Marshalltown – Pella Foot & Ankle Clinic

How did you hear about us? Newspaper Yellow Pages Internet Friend/Family Provider

Patient's Full Name: ______________________________ **DOB:** ________________

Social Security Number:______________________________ **Gender:** Male Female

Address: ____________________ **City:**____________________**State:**________ **Zip Code:**__________

Home Phone: ________________ **Cell Phone:** ________________ **Email:** ________________

Preferred Language: English Spanish Other:____________ **Marital Status:** Married Single Divorced Widowed

If patient is a minor, Parent Guardian Name:______________________________ **DOB:** ______________

Insurance:______________ **Policy Holder Name & D.O.B**______________________________

Emergency Contact Name ____________________ **Phone Number**____________________

Employer: ________________________ **Employer Phone:** ________________________

Primary Care Doctor: ________________________ **Referring Physician:** ________________

May we leave medical information (appointments, lab/imaging results, billing, diagnosis/plan) on your home answering machine, voicemail, or with a friend/family member? Yes No

Name:____________________**Relationship:**________________**Phone #:**______________

Authorizations & Policies - Please review our policies, and sign below.

Responsibility of Payment: I understand deductibles, co-pays, and co-insurance are due at the time of services, 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 that are not covered by insurance or legal settlement. I understand I must pay these in a timely manner (90 days) and that I may contact the billing department to make payment arrangements if I am unable to pay these. I understand that my account will be placed in collections if I do not pay these in a timely manner. I am responsible for paying any interest on charges incurred by the collection agency to my balance. If patient is a minor, responsibility of payment falls to the parent or guardian. It is my responsibility to notify Central Iowa Podiatry of any changes in insurance or demographics. I authorize payment to Central Iowa Podiatry for all medical/surgical benefits from my insurance company.

Cancellations/No-Shows: Central Iowa Podiatry requires a 24-hour notice of any changes to your appointment, although we do understand this is not possible in every situation. However, if you fail to show for 3 or more appointments without notifying us or the same day as the appointment you may be discharged from our care. If you are more than 10 minutes late to your appointment you may be asked to reschedule.

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

Acknowledgement 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: ____

Past Surgical History:

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

Allergies:

1. ________________
2. ________________
3. ________________
4. ________________
5. ________________
6. ________________
7. ________________
8. ________________
9. ________________
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 ____________

Pharmacy Name & Location (We can obtain your medication list electronically)

____

____

Height:__________

Weight:__________

Social History- Please circle all that apply.

Alcohol consumption? Non-Drinker Social Moderate Heavy

Exercise Frequency? Never Moderate Often

Tobacco Usage? Never Former Smoker Light Smoker Heavy Smoker Chewing Tobacco

Review of Systems – Please circle any symptoms you are experiencing.

Constitutional:
Chills
Fever
Nausea/Vomiting
Fatigue

Cardiovascular:
Cold Feet
Chest Pain
Heart Murmur
Palpitations
Pacemaker
Blood Thinners
Leg Cramps

Respiratory:
Wheezing
Shortness of Breath

Neurological:
Burning
Uncontrolled Movements
Numbness
Tingling
Dizziness

Musculoskeletal
Ankle Pain
Foot Pain
Heel Pain
Swelling
Stiffness
Difficulty Walking

Integumentary
Poor healing wounds
Rash
Blisters
Itching

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

☐ Cancer	M F B S	☐ High Cholesterol	M F B S
☐ Heart Disease	M F B S	☐ Hypertension	M F B S
☐ Diabetes	M F B S	☐ Stroke	M F B S
☐ Kidney Failure	M F B S	☐ Other ___________	M F B S
☐ Heart Attack	M F B S	☐ Other___________	M F B S

What are we seeing you for today:____

____

____

Duration of symptoms:____

Attempted treatments: ____

____

History of injury or trauma to the area: _________________________________

____

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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