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: _____

Home Phone: _____ Cell Phone: _____

Race/Ethnicity: White Hispanic/Latino American Indian/Alaskan Native African American Asian Pacific Islander

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

If patient is a minor, Parent Guardian Name:_____ DOB: _____

Emergency Contact Name/Number: _____ Email: _____

Employer: _____ Employer Phone: _____

Primary Care Doctor: _____ Referring Physician: _____

May we leave medical information (appointment reminders, lab results, insurance coverage etc) on your home answering machine, voicemail, or with a family member? Yes No

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. 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 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 copay 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