First Podiatry of Arizona

PATIENT INFORMATION

Today's Date: _____ Date of Birth: _____

Patient's Name _____ Cell Phone: _____
(First Name) (MI) (Last Name)

Address: _____ Home Phone: _____
(Street) (City) (State) (Zip)

Patient's Employer: _____ Work Phone: _____

Social Security #: _____ Sex: Male ___ Female ___ Age: _____ Marital Status: M S D Other

Responsible Party: _____ Relation: _____ DOB: _____ SS#: _____

Primary Care Physician: _____ Phone: _____ Did he/she refer you? _____

How were you referred to our office? _____

INSURANCE ***(Please complete all insurance information)***

Primary Insurance Information

Insurance Name: _____

Policy Holder: _____ DOB _____

ID# _____ Group # _____

Employer: _____

Is this a work related injury? ___ If yes, date of injury: _____

Claim # _____ Adjuster: _____

Secondary Insurance Information

Insurance Name: _____

Policy Holder: _____ DOB: _____

ID# _____ Group# _____

Employer: _____

Carrier: _____

Phone #: _____

ASSIGNMENT OF BENEFITS: I authorize the release of information necessary to process this claim and hereby assign my insurance benefits to be paid to First Podiatry of Arizona. I acknowledge financial responsibility for services which are not covered by my insurance company.

Signature: _____ **Date:** _____

For Office Use Only

Information above is updated and correct.

_____ _____

Signature: Date:

Patient Name _____ Date _____

Please indicate which foot problems you now have or have had by checking yes or no

Ankle Pain	☐ yes ☐ no	Flat feet	☐ yes ☐ no	Ingrown toenails	☐ yes ☐ no
Athlete's Foot	☐ yes ☐ no	Foot or leg cramps	☐ yes ☐ no	Plantar warts	☐ yes ☐ no
Bunions	☐ yes ☐ no	Heel pain	☐ yes ☐ no	Tired feet	☐ yes ☐ no
Corns and Calluses	☐ yes ☐ no	Cramps or numbness in feet or legs	☐ yes ☐ no	Swelling in ankles or feet	☐ yes ☐ no

Other _____

Have you ever been to a Podiatrist before?
☐ Yes ☐ No
If yes, please list
Name _____
Last Visit _____
Treatment _____

Height _____ Weight _____ Shoe Size _____

Athletic activities in which you participate
(Please list and indicate frequency.)
_____
_____

Your occupation _____
Cigarette/Tobacco use _____
Years smoked _____ Pks / Yrs
Drug Usage _____

PERSONAL & FAMILY HISTORY

Please check appropriate box.

	Personal	*Family*	*If yes, please indicate relationship*
Diabetes	☐ yes ☐ no	☐ yes ☐ no	
Hypertension	☐ yes ☐ no	☐ yes ☐ no	
Heart Disease	☐ yes ☐ no	☐ yes ☐ no	
Gout	☐ yes ☐ no	☐ yes ☐ no	
Head Trauma	☐ yes ☐ no	☐ yes ☐ no	
Asthma	☐ yes ☐ no	☐ yes ☐ no	
Lung disease	☐ yes ☐ no	☐ yes ☐ no	
Liver disease	☐ yes ☐ no	☐ yes ☐ no	
Hepatitis	☐ yes ☐ no	☐ yes ☐ no	
Ulcers or Stomach Problems	☐ yes ☐ no	☐ yes ☐ no	
HIV	☐ yes ☐ no	☐ yes ☐ no	
Depression/Anxiety	☐ yes ☐ no	☐ yes ☐ no	
Rheum. Arthritis	☐ yes ☐ no	☐ yes ☐ no	
Osteoarthritis	☐ yes ☐ no	☐ yes ☐ no	
Fibromyalgia	☐ yes ☐ no	☐ yes ☐ no	
Bleeding Problem	☐ yes ☐ no	☐ yes ☐ no	
Neurological Problems	☐ yes ☐ no	☐ yes ☐ no	
Skin Disorders	☐ yes ☐ no	☐ yes ☐ no	

Allergies - Reaction or drug side effects:

___ None	___ Aspirin	___ Penicillin	___ Sulfa	___ Topical Meds	___ Local Anesthetic
___ Pain Medication	___ Cortisone	___ Tape	___ Iodine	(internal or external)	___ Other

What antibiotics or pain meds have you used in the past? _____

Current Medications: (attach list if you have)

	Drug	Dose
1.		
2.		
3.		
4.		
5.		
6.		

Past Surgeries & Hospitalizations; dates:
(List most recent first)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

If you require more space, ask for another sheet of paper.