WELCOME TO THE FOOT CENTER

Please print and complete the following information for your case history file.

PATIENT INFORMATION

MR.___ MRS.___ MISS___ MS.___ Today's Date:

Patient's Last Name:	Patient's First Name:	Patient's Middle Name:	Patient's Birth date:

Parent/Guardian Name If Patient is a Minor:	Patient's Social Security Number:	Driver's License #:

Mailing Adress/Rural Route/Box No. City State ZIP

E-Mail address:	Home Phone #:	Cell Phone #:

Employer (name, address) Department or extension	Work Phone Number:

Emergency Contact:	Phone #:	Work or Cell Phone Number

Spouse's name & employer: Department or extension	Cell Phone Number	Work Phone Number:

Who may we thank for referring you? (relative, friend, physician) Please provide name and address:

If not referred, how did you learn about The Foot Center?

OTHER(Please Specify)_____ YELLOW PAGES_____ NEWSPAPER_____ BILLBOARD_____ OFFICE SIGN_____

HEALTH INFORMATION

What is your foot problem?	How long have you had this problem?	Have you seen a doctor for this problem?

Name of your family physician?	May we contact?	Date last seen by your doctor:

Are you DIABETIC?_____	Are you pregnant? _____ Do you smoke? _____ Packs/Day_____	**Have you taken Cortisone, Prednisone, Steroids in the last year?** _____

Please check any condition(s) you currently have, or have had in the past:

Arthritis _____	Kidney disorder _____	High blood pressure _____	Hepatitis _____	Gout _____
Asthma _____	Muscle disorders _____	Low blood pressure _____	Thyroid disease _____	Implants_____
Cancer _____	Heart disease _____	Sickle cell anemia _____	Bleeding problems _____	**NONE**_____
Epilepsy _____	Difficult healing _____	Anemia _____	Artificial Joints_____	

Are you allergic to any of the following:

Iodine (seafood) _____	Penicillin _____	Codeine _____	Mercurial _____
Adhesive tape _____	Novocaine	Aspirin _____	Other (specify) _____
Sulfa drugs _____	**NONE known** _____		

List any medications you are currently taking:

I HEREBY GIVE DR. FRANK J. HENRY PERMISSION TO EXAMINE AND TREAT MY FOOT CONDITION AT THE FOOT CENTER.

Patient's/Parent's/Guardian's Signature

_____ **Date:** _____

PAYMENT IS DUE WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

Do feel free to discuss this with the Clinic Manager prior to treatment if you have any questions.

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Please print and complete the following information for your case history file.

INSURANCE INFORMATION

Do you have insurance? Yes _____ No _____

If you are not the Policy holder on your insurance card, please provide the following information:

Policy Holder's Name_____ DOB_____ SSN (Must Have)_____

Primary Insurance Name _____

Policy #_____ Group #_____

Policy Holder's Name_____ DOB_____ SSN (Must Have)_____

Secondary Insurance Name: _____

Policy #_____ Group #_____

WILL BE PAYING BY CASH___ CHECK___ CREDIT ____ CARD(MC/VISA) # _____ EXP._____

***I understand that insurance is a contract between myself and the insurance company and that the doctor does not determine any amount that insurance will pay on my account. The fee for service is due to the doctor regardless of any action by the insurance company.* **INITIALS:* _____**

***I understand that my appointment has been reserved specifically for me, and that a $35 charge will be applied for appointments missed or canceled without 24 hours notice.* **INITIALS:* _____**

Acknowledgement 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 chose) and understood the Notice.

_____ _____

Patient Name (Please Print) Date

_____

Signature

_____

Parent of Patient (if applicable)

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