

Foot Specialist Associates, PC

950 E. Harvard Avenue, Suite 300, Denver, CO 80210 (303)722-6864
7780 S. Broadway, Plaza III Building, Suite 355, Littleton, CO 80122 (303)470-1830

Today's Date _____ Please do not use lotion or creams the day of your appointment
Patient Name _____ Date of birth _____ Age _____ Sex _____
Mailing Address _____
City _____ State _____ Zip _____
Home No. _____ Cell No. _____ Social Security No _____
Marital _____ Parent/Guardian Name _____ Daytime No. _____
Employer _____ Occupation _____
Work No _____ May we call you at work _____ Spouse Name _____
Primary care physician _____ Last visit _____
How did you hear about us _____
Emergency contact _____ Phone _____

Insurance Information

Do you have a co-pay _____ I understand that my co-pay is due at every visit. Initial here _____
Policyholder's Name _____ Policyholder's DOB _____
Insurance Company _____ Employer _____
Policyholder's Social Security _____ Group No _____

Secondary Insurance (if applicable)

Policyholder's Name _____ Policyholder's DOB _____
Insurance Company _____ Employer _____
Policyholder's Social Security _____ Group No _____

Assignment and Release

- I am aware that my account and knowledge of benefits is ultimately my responsibility. Foot Specialist Associates, PC cannot guarantee payment, benefits or coverage from my insurance company.
- I authorize my insurance benefits to be paid directly to Foot Specialist Associates, PC.
- I authorize the facility to release medical information for treatment, payment or daily operations.
- If we cannot fax this information upon request, please initial here.
- I voluntarily consent to examination and treatment for myself or the above dependent patient.
- I will inform Foot Specialist Associates, PC immediately of any insurance or personal information changes
- All unpaid personal balances over 30 days are charged a minimum \$5 fee or 1.5% interest per month.

I have read all of the above information and asked the necessary questions. I understand my obligations as outlined by this release. I understand that this release is valid for one (1) year from the date of signing.

Parent/Patient/Guardian Signature

Date

Patient History

Name _____ Date _____

Describe your foot problem _____

Past Medical History

Please check all that apply

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Bowel disease | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> Skin disease |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Venereal diseases |

Please list any other diseases below _____

Allergies

Please check all that apply

- | | | |
|--|--|---|
| <input type="checkbox"/> Adhesives/tapes | <input type="checkbox"/> Mercurial | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Merthiolates | <input type="checkbox"/> Tetanus antitoxin or serum |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Mycins or other antibiotics | <input type="checkbox"/> Other, please list: |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Novocain | _____ |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Nylon/plastics | _____ |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Penicillin | _____ |

Current Medications

Please list any prescriptions, over-the-counter, and vitamins

_____	_____
_____	_____
_____	_____

When was your last tetanus shot? _____

Have you ever had a blood transfusion? _____

Is there any chance that you might be pregnant? _____

Name _____ Date _____

Habits

Smoking:

No. packs per
Day _____

How long? _____

Alcohol:

Daily
amount _____

Type _____

Caffeine:

Daily
amount _____

Type _____

Surgical History

Operation

Year

Hospitalizations

Other than surgery

Reason

Year

Injury

Fractures, sprains, other

Injury

Year

Family History

Please check all that apply

Disease	Mother	Father	Mother's Parents	Father's Parents	Siblings	Children
Bleeding disorders						
Cancer						
Diabetes						
Epilepsy/convulsions						
Glaucoma						
Heart disease						
High blood pressure						
Kidney disease						
Mental Illness						
Osteoporosis						
Stroke						
Thyroid disease						