SHORELINE FOOT & ANKLE ASSOCIATES, PC

PATIENT HISTORY

PATIENT: ______________________________ DATE: ______________

BIRTH DATE: ____________________AGE: ______ Patient's SSN #: ______________________

MALE: ______ FEMALE: ______ Marital Status : **M S W D P MINOR**

ADDRESS: ______________________________ Apt./ Unit/ Lot # __________

CITY: ______________________________ STATE ________ ZIP: ______________

PRIMARY PHONE: ____________________ **ALT PHONE:** ____________________

EMAIL: ______________________________

Spouses Name ______________________Spouses Birth Date______________

PARENT's NAME (IF PATIENT IS A MINOR): ____________________ **PARENT's BD:** ______________

EMPLOYER: ______________________________WK PHONE: ____________________

EMERGENCY CONTACT: ______________________ PHONE: ____________________

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FAMILY DOCTOR: ______________________________ PHONE: ______________

REFERRED BY: ______________________________

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1ST Insurance: ______________________________ **OFFICE VISIT CO-PAY** $ ______________

2ND Insurance: ______________________________

IF YOU, THE PATIENT, ARE THE SUBSCRIBER (ONE WHO CARRIES THE INSURANCE) **…..**

YOU DO NOT NEED TO FILL OUT SUBSCRIBER INFORMATION BELOW:

SUBSCRIBER'S NAME: (if person is other than the patient) ______________________________

Birth Date: ____________________ Subscriber's SSN: ______________________

Employer: ______________________________ Relationship To Patient: ______________

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WOULD YOU CONSIDER YOUR CURRENT HEALTH TO BE :

CIRCLE ONE: GOOD FAIR POOR

HEIGHT: ______**WEIGHT:** ________ **SHOE SIZE:** ________ DO YOU BRUISE EASILY? ______

ARE YOU ON A SPECIAL DIET? **YES**____**NO**______ /// ARE YOU PREGNANT? **YES**_____**NO**_____

DO YOU SMOKE? **YES**____ **NO**____ /// **FORMER SMOKER?** YES____ NO____

DO YOU DRINK? **YES**_____ **NO** _____ **OCCAS** ____

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WHAT IS YOUR FOOT/ANKLE PROBLEM: ______________________________

WHEN DID THIS PROBLEM START: ______________________________

WAS THERE ANY PREVIOUS FOOT/ANKLE TREATMENT: YES ____________ NO ___________

IF YES, DESCRIBE: ______________________________

ANY SPECIFIC INJURY TO YOUR FOOT/ANKLE: YES _____________ NO __________________

IF YES DESCRIBE: ______________________________

CURRENT MEDICATIONS: (or bring list and we'll copy it here)________________________________

____

____

MEDICAL ALLERGIES: ____

____

SURGERY WITHIN THE LAST 5 YEARS: ____

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PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE

- ❒ ANEMIA
- ❒ DIABETES
- ❒ KIDNEY DISEASE
- ❒ ARTHRITIS
- ❒ EPILEPSY
- ❒ POLIO
- ❒ ASTHMA
- ❒ GLAUCOMA
- ❒ STROKE
- ❒ BLEEDING DISORDER
- ❒ GOUT
- ❒ TUMORS
- ❒ HIGH CHOLESTEROL
- ❒ HEART TROUBLE
- ❒ ULCERS
- ❒ CANCER-----If yes, what type?___________________________
- ❒ HIGH BLOOD PRESSURE
- ❒ VARICOSE VEINS… …. DVT's? **or** Blood Clots?

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DO YOU HAVE OR IS THERE A CHANCE YOU HAVE?

TB: YES ____ NO _____/ **HIV:** YES ____ NO ____/ **Hepatitis:** YES ____ NO ____ /

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RACE: (check all that apply…required for your medical records)

- o WHITE
- o BLACK
- o AMER INDIAN/ALASKAN
- o HAWAIIAN OR PACIFIC
- o ASIAN
- o NOT SPECIFIED

ETHNICITY: (check all that apply….required for your medical records)

- o White / NOT Hispanic or Latino
- o Hispanic or Latino
- o Not Specified

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS AND THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THE CLAIM TO *Shoreline Foot & Ankle Associates, P.C.* I UNDERSTAND I WILL BE RESPONSIBLE FOR ANY OUTSTANDING BALANCE NOT COVERED BY MY INSURANCE.

SIGNATURE: *DATE:*