PATIENT INFORMATION

Thank you for selecting our health care team. To better serve you, we need the following information. Please print. If you have any questions please ask a member of our staff.

All information will be confidential

PERSONAL INFORMATION

Patient Name _____ _____
First Name Middle Initial Last Name Social Security Number

Address _____ City _____ St_____ Zip _____

Home Phone ( )_____ Cell Phone ( )_____

☐ Male ☐ Female Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered

Patient's Employer _____ Employer Phone Number ( ) _____

Spouse/Parent Name _____ Birthdate _____ _____
Social Security Number

Spouse/Parent Employer _____ Employer Phone Number ( ) _____

Emergency Contact _____ _____ ( ) _____
Name Relationship Phone Number

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION

Who is responsible for this account _____ _____
Subscriber Name Relationship to Patient

_____ _____
Subscriber Birthdate Social Security Number of Subscriber

A member of our staff will request your insurance cards so that a copy can be placed in your medical chart for billing purposes.

Insurance Assignment and Release

(To Be Signed by all Patient's/Parent or Guardian)

I certify that I have insurance coverage with _____ and assign directly to **Troy Foot & Ankle, PC**
Name of Insurance Company(ies)
all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____ _____
Signature of Patient/Guardian Relationship to Subscriber Date

Medicare/Medigap Authorization

(To be Signed by Medicare Patient's Only)

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made to **Troy Foot & Ankle, PC** for any services furnished to me by that provider. To the extend permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits for related services.

_____ _____
Signature of Medicare Recipient/Guardian Date

MEDICAL HISTORY

What are we seeing you for today? _____

_____

Please check any of the following conditions that you have experienced or are currently experiencing.

AIDS/HIV	☐	Eye Problems	☐	Radiation Treatment	☐	**ALLERGIES**	
Anemia	☐	Foot or Leg Cramps	☐	Rash	☐	☐ **Adhesive/Tape**	
Angina	☐	Gout	☐	Respiratory Disease	☐	☐ **Anticoagulants**	
Arthritis	☐	Headaches	☐	Rheumatic Fever	☐	☐ **Aspirin**	
Artificial Heart Valves or Joints	☐	Heart Disease	☐	Sinus Problems	☐	☐ **Codeine**	
Asthma	☐	Hemophilia	☐	Special Diet	☐	☐ **Demerol**	
Back Problems	☐	Hepatitis or Jaundice	☐	Stroke	☐	☐ **Iodine**	
Bleeding Disorders	☐	High Blood Pressure	☐	Swollen Neck Glands	☐	☐ **Local Anesthetics**	
Cancer _____	☐	Kidney Problems	☐	Tuberculosis	☐	☐ **Novocaine**	
Chemical Dependency	☐	Liver Disease	☐	Ulcers	☐	☐ **Penicillin**	
Circulatory Problems	☐	Low Blood Pressure	☐	Varicose Veins	☐	☐ **Seafoods**	
Diabetes	☐	Neuropathy	☐	Venereal Disease	☐	☐ **Sulfa**	
Ear Problems	☐	Phlebitis	☐	Weight Loss, unexplained	☐	☐ **Other** _____	
Epilepsy	☐	Psychiatric Care	☐				

1. Do you smoke? ☐ YES ☐ NO
   If yes, how much? _____
2. Do you consume alcoholic beverages? ☐ YES ☐ NO
   If yes, how much? _____
3. Do you use any illicit drugs? ☐ YES ☐ NO
4. If you are a **diabetic**, how long have you been? _____
   Last blood sugar? _____
   Do you have numbness/tingling in your feet? YES NO
5. Occupation: _____

Shoe Size _____ Height _____ Weight _____

Surgeries you have had _____

_____

_____

Hospitalization other than for the surgeries listed above _____

_____

_____

Family Physician/Internist _____ Last visit date _____

Address _____

Phone Number _____

Are you now, or have you been under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain _____

_____

MEDICATIONS: Include prescriptions, over-the-counter medications and vitamins

_____

_____

_____

Do you take oral contraceptives? ☐ YES ☐ NO

TREATMENT CONSENT:

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Guardian or Personal Representative — Relationship to Patient