Sarasota Foot Care Center, PA

Please print clearly

Account Number ______________________________

Name ____
(Last) (First) (Middle)

Local Address ____

____
City State Zip

Northern Address ____

____
City State Zip

Local Phone ____________________ **Cell Phone** ____________________ **Northern Phone** ____________________

Date of Birth ______________ **Age** _____ **Gender:** ☐ **Female** ☐ **Male** **Social Security #** ____________________

Email Address ____

Race:	**Ethnicity:**	**Smoking:**	**Marital Status:**	**Language:**	**Employment:**	**Student:**
☐ Caucasian	☐ nonHispan	☐ Daily	☐ S	☐ English	☐ Full time	☐ Full time
☐ Black	☐ Hispanic	☐ Some days	☐ M	☐ Spanish	☐ Part time	☐ Part time
☐ Asian		☐ Former	☐ D	☐ Other		
		☐ Never	☐ W			

Occupation______________________________ **Employer**____________________ **Phone** ______________

Work address ____

Next of Kin __________________________________ **Phone #** ______________________________

Responsible party (for minor) ______________________________ **Relationship** ____________________
(Last) (First)

Their employer ____________________ **Occupation** ____________________ **Phone** ____________________

Primary Insurance ______________________________ **Secondary Insurance** ______________________________

Name of policy holder ______________________________ **DOB** __________ **SS#** ______________________

Is Insurance through employer? _____ Yes _____No **Yours or Spouse?** ______________________________

Pharmacy ______________________ **Location** ____________________________ **Phone #** ______________

IF WE CANNOT VERIFY YOUR INSURANCE BENEFITS BEFORE YOU ARE SEEN, YOU WILL BE ASKED FOR PAYMENT IN FULL

IF THIS VISIT IS RELATED TO A WORK INJURY, AUTO ACCIDENT, OR INVOLVES ANY TYPE OF LIGITATION, PLEASE NOTIFY THE RECEPTIONIST IMMEDIATELY

I hereby authorize the release of any medical information necessary for processing claims and payment of medical benefits to myself or the party who accepts assignment (lifetime signature)**. I understand that, as the patient receiving medical treatment, I am responsible for payment regardless of insurance coverage or litigation.**

Patient Signature ____ **Date** ____________________
(Responsible party)

(over)

Account Number:

SARASOTA FOOT CARE CENTER, PA

Name_______________ Birthdate__________ Date______________

Height______________ Weight_______ _______ _______ Shoe size__________

Reason for visit____
____
____

Whom may we thank for referring you to our office?_______________ Date of onset__________

Medical Doctor _______________ Date last seen__________ Former Podiatrist__________

Medical History (check only those items that apply)

☐ Anemia	☐ CVA (stroke)	☐ GI Ulcers	☐ Leg cramps/numbness
☐ Arthritis	☐ Depression	☐ Heart disease	☐ Liver disease
☐ Asthma	☐ Diabetes	☐ High blood pressure	☐ Mitral valve prolapse
☐ Autoimmune disease	diet/oral/insulin ___yr	☐ High cholesterol	☐ Peripheral vascular dis
☐ Blood disease	☐ Epilepsy	☐ Hyperthyroidism	☐ Rheumatic fever
☐ Cancer	☐ Eye pathology	☐ Hypothyroidism	☐ Varicose veins
☐ Charcot joint	☐ Gastric reflux	☐ Kidney disease	☐ Osteoporosis

Other Medical problems (please list)______________________ ______________
____

Surgical History (check only those items that apply)

☐ Angioplasty	☐ Cataract	☐ Gall bladder sx	☐ Kidney removal	☐ Pacemaker
☐ Appendectomy	☐ Colonoscopy	☐ Heart by-pass	☐ Kidney stone sx	☐ Prostate surgery
☐ Arterial by-pass	☐ C-section	☐ Heart catheter	☐ Knee replacement	☐ Tonsillectomy
☐ Back surgery	☐ D and C	☐ Hernia repair	☐ Mastectomy	☐ Venous ligation
☐ Breast biopsy	☐ Endoscopy	☐ Hip replacement	☐ Neck surgery	__________
☐ Carotid artery sx	☐ Foot surgery	☐ Hysterectomy	☐ Open heart sx	

Other Surgery (please list)____
____
____

Medications (please list)____
____
____

Family History (please circle if positive)

	Diabetes	Heart disease	Cancer	High blood pressure
Mother	yes	yes	yes	yes
Father	yes	yes	yes	yes
Siblings	yes	yes	yes	yes

Current Activities and Social History (please check)

☐ Alcohol (frequency)__________ Tobacco _______ppd Date quit__________ Caffeine (type)______________

☐ PhysicalActivities____

Allergies (please check)

☐ Novocaine	☐ Codeine	☐ Cortisone	☐ Sulfa
☐ Aspirin	☐ Penicillin	☐ Adhesive tape	☐ Other__________

Review of systems (filled out by nurse) **Mental status** alert and oriented / alert but not oriented / confused / lethargic

Head Eyes dizziness / syncope / headaches / double vision / infection / total blindness

Ears Nose Throat dysphagia / hoarseness / hearing loss / infection / tinnitus / epistaxis / otalgia / sores

Respiratory asthma / bronchitis / dyspnea / orthopnea / hemoptesis / emphysema

Cardiovascular hypertension / murmurs / chest pain / edema / claudication / ulceration / phlebitis / heart attack

Gastrointestinal jaundice / cirrhosis / hepatitis / abnormal stool / GI ulcer / nausea / vomiting

Genitourinary dysuria / polyuria / hematuria / pyuria / nocturia / renal dialysis / incontinence / urinary infection

Musculoskeletal joint pain / joint swelling / muscle pain / poststatic dyskinesia / weakness / back pain

Dermatologic rash / bleeding / bruising / pruritis / hypertrophic nails / ulcer / skin infection / psoriasis

Neurologic paralysis / stroke / tics / tremors / seizures / tingling / numbness

Allergic/immunologic allergies / anaphylactic reactions / HIV / immunosuppressed / recurring infections **Tech**__________