Alan G. Shier, DPM *Foot Care & Surgery Center*

PATIENT INFORMATION

Name_____ **Date** _____
(First) (Last) (MI)

Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone (____) _____ **Cell Phone (____)** _____

SSN _____-_____-_____ **Date of Birth** _____/_____/_____ **Age** _____

Sex: M F Who referred you to our office? _____

Email _____Primary Care physician_____

PERSON RESPONSIBLE FOR PAYMENT (*if other than patient*)

Name_____ **Relationship** _____

Address_____ **Home Phone (_____)** _____

Employer _____ **Business Phone (_____)** _____

EMERGENCY CONTACT

Name_____ **Phone (____)** _____ **Relationship**_____

INSURANCE INFORMATION

Primary Insurance Company _____**Policy #** _____

Policy Holder _____ **DOB** _____/_____/_____

Secondary Insurance Company _____ **Policy #** _____

Policy Holder _____ **DOB** _____/_____/_____

INSURANCE AUTHORIZATION: I request that payment of authorized benefits be made to the above facility on my behalf, for any services provided to me. I authorize any holder of medical and other information about me can be released to Medicare and it's agents, any insurance company, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, or any other information needed to determine benefits for related services. I agree to pay for all charges not covered by my insurance. I authorize a copy of this authorization to be used in place of the original document.

Signed _____ **Date** _____
(Patient or person authorized to consent for patient)

MEDICAL INFORMATION

INFORMATION ABOUT CURRENT PROBLEM

Describe your foot/ankle problem_____

_____

How long has it bothered you? _____ **Can you recall any type of injury?** _____

Please rate your pain (*circle one*) **1** (mild) **2 3 4 5** (moderate) **6 7 8 9 10** (severe)

What makes your condition worse? _____

What makes your condition better? _____

Have you tried to treat this condition? (soaks, pads, changing shoes, medications) YES NO

If YES, please explain_____

Have you been treated by another doctor for this please? YES NO If so, who? _____

When? _____

GENERAL HEALTH INFORMATION

Are you currently under the care of a physician? YES NO

Are you DIABETIC? YES NO

Do you currently take INSULIN? YES NO

Height_____ **Weight**_____

CHECK ALL THAT YOU HAVE OR HAVE HAD A PROBLEM WITH:

___ Asthma ___Arthritis ___ Foot Ulcers
___ Bladder ___Anemia ___ Stomach Ulcers
___ Gout ___Heart ___ Lung
___ Kidney ___Liver ___Frequent Infection
___ Skin ___Circulation ___ High Blood Pressure

MEDICATIONS AND DOSAGE

(Please list all)

_____
_____
_____
_____
_____

DRUG ALLERGIES

(Please list all allergies or sensitivities)

_____
_____
_____