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## Patient Information

**Today's Date**: _____

Full Name:_____ Sex: ☐ Male ☐ Female
FIRST MIDDLE LAST

Date of Birth:_____ Social Security Number: _____
*NEEDED FOR INSURANCE VERIFICATION*

**Race**: ☐ White
☐ Hispanic or Latino
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian
☐ Hawaiian/PacificIslander

**Ethnicity**: ☐ Hispanic or Latino
☐ Not Hispanic or Latino

**Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address: _____ Zip Code: _____
Mobile Number: _____ Home Number: _____
Email Address: _____

**Emergency Contact:**
Name: _____ Phone: _____ Relationship: _____

**Work Status:**
☐ Full-time ☐ Part-time ☐ Student Occupation: _____
☐ Retired ☐ Unemployed ☐ Disabled Employer Name: _____

**Current Physicians**
Primary Care Physician: _____ **Date Last Seen**: _____
Office Name: _____ Phone: _____ City/State: _____
Do you see a Cardiologist? ☐Yes ☐No Physician Name: _____
Do you see a Vascular Doctor? ☐Yes ☐No Physician Name: _____

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Do you see a Neurologist? ☐Yes ☐No Physician Name: _____

Do you see Pain Management? ☐Yes ☐No Physician Name: _____

**Pharmacy Name:** _____ Zip Code: _____ Phone: _____

**How did you hear about us?** ☐ Provider ☐ Friend ☐ Google ☐ Facebook ☐ Instagram ☐ Other:_____

## Guarantor Information:

*Only complete if patient is not responsible party*

Full Name: _____ Sex: ☐ Male ☐ Female

Date of Birth:_____ Social Security Number: _____

Home Address:_____ Zip Code:_____

Mobile Number: _____ Home Number: _____

## Insurance Information:

*It is very important you provide us with accurate information so that we can bill insurance.

Primary: _____ Effective Date: _____ ID#: _____

Secondary: _____ Effective Date: _____ ID#: _____

Tertiary: _____ Effective Date: _____ ID#: _____

I certify that the above insurance information is accurate and truthful. If the information I have provided is incorrect or not complete, I understand that Highlands Foot & Ankle, LLC can transfer any charges to self-pay, and I will be responsible for full payment. I agree to provide my insurance cards to Highlands Foot & Ankle, LLC for verification. I agree to pay the specialist copay, set by my insurance company, upon check-in. I agree to pay the deductible amount, or any amount that my insurance company has left me responsible. If my insurance policy has expired, Highlands Foot & Ankle, LLC will release all charges to self pay, and I understand that I will be responsible for payment. I understand it is my responsibility to obtain all referrals and/or authorizations granted by my insurance company before being seen, otherwise I can become responsible for all charges.

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Due to the Affordable Care Act, you may be responsible for a portion of your deductible if it has not already been met.

I understand and agree to the terms and conditions stated above.

| _____ | _____ | _____ |
|---|---|---|
| Print Name | Signature | Date |

## Medical History

Weight: _____ Height: _____ Shoe Size:_____ ☐ Regular ☐ Wide

**Allergies** ☐ **No known allergies**

☐ Penicillin ☐ Tetracyclines ☐ Sulfa ☐ Benadryl ☐ Local Anesthesia

☐ IV Contrast ☐ Iodine topically ☐ Latex ☐ Adhesive tape

☐ Other: _____

Describe reaction: _____

**Medical Conditions**

☐ Diabetes Type 1 ☐ Diabetes Type 2 ☐ Neuropathy ☐ Lymphedema

☐ High Cholesterol ☐ High B/P ☐ Low B/P ☐ Sleep Apnea

☐ Pacemaker ☐ Heart Failure ☐ Stroke ☐ COPD

☐ Sickle Cell Anemia ☐ Hepatitis: _____ ☐ HIV/AIDs ☐ Anemia

☐ Osteoporosis ☐ Arthritis ☐ Rheumatoid ☐ Lupus

☐ Liver Disease ☐ Kidney Disease ☐ Dialysis ☐ Blood Clots

☐ Birth defects: _____ ☐ Back Injury ☐ Fibromyalgia

☐ Cancer: _____ ☐ Skin disorder: _____

Are you currently pregnant? ☐ Yes ☐ No Breastfeeding? ☐ Yes ☐ No

Please list all other medical conditions not stated above: _____

_____

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Please list all surgeries and year: _____
_____

**Podiatry Medical History**

Reason for today's visit? _____

Is this a recent traumatic injury? ☐ Yes ☐ No Date of Injury? _____
If so, is it work related? ☐ Yes ☐ No
Sports related? ☐ Yes ☐ No What sport? _____
Motor vehicle accident? ☐ Yes ☐ No

Have you ever been treated for foot/ankle issues in the past? ☐ Yes ☐ No
If so, please explain: _____
_____

Do you have calf pain? ☐ Yes ☐ No If so, when does it occur? ☐ Walking ☐ At rest

## Family Medical History

| Member | Age | | Medical Conditions |
|---|---|---|---|
| | | ☐ Living<br>☐ Deceased | ☐ Diabetes ☐ Stroke ☐ High B/P ☐ Arthritis<br>☐ Auto-immune disorder: _____<br>☐ Cancer: _____<br>Please list any not stated: _____<br>_____<br>_____ |
| | | ☐ Living<br>☐ Deceased | ☐ Diabetes ☐ Stroke ☐ High B/P ☐ Arthritis<br>☐ Auto-immune disorder: _____<br>☐ Cancer: _____<br>Please list any not stated: _____<br>_____<br>_____ |

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## Social History

**Tobacco** Use: ☐ Never ☐ Former, year quit: _____ ☐ Current, years used: _____

Type: ☐ Cigarettes ☐ Vape ☐ Cigar ☐ Chew ☐ Smokeless ☐ Pipe
Frequency: _____ Exposure to secondhand smoke? ☐ Yes ☐No

Do you drink **caffeine**? ☐ Coffee ☐ Tea ☐ Energy drinks Frequency?
_____

Do you drink **alcohol**? ☐ Yes ☐ No If so, what & how often?
_____

Do you use **recreational drugs**? ☐ Yes ☐ No Frequency?
_____

☐ Marijuana ☐ Cocaine ☐ Meth ☐ Heroin ☐ Prescription drugs not prescribed to you
☐ Other: _____

**Diet Type**: ☐ Balanced ☐ Diabetic ☐ Vegetarian ☐ Vegan ☐ Other:
_____

Do you **exercise**? ☐ Yes ☐ No If yes, how often & what type?
_____

☐ I feel safe at home ☐ I feel safe with the person who I am here with today
☐ I understand I can talk to any staff member here, at any time, if I do not feel safe
(NHTH) 1-888-373-7888

## Medication Record

List all medications you are currently taking, including all over the counter & supplements.

☐ I have provided a printed list of medications

| Medication Name | Dosage | Reason for Medication |
|---|---|---|
| | | |

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