

Foot Specialist Associates
950 E Harvard, Suite 300
Denver, CO 80210
(303)722-6864
Fax: (303)722-5113

PATIENT RECORD

Name: _____ ID: _____
Street: _____ City/State: _____ Zip: _____
Phone: _____ SocSecNo: _____ Sex: _____
Cell: _____ Birthdate: _____ Age: 0
Email: _____ Marital _____
Employer: _____ Street: _____
Phone: _____ City/State: _____ Zip: _____

Responsible Party:

Last Name: _____ First _____
Street: _____ City/State: _____ Zip: _____
Phone: _____ Relation: _____

Referred _____ FamilyPhy: _____
Contact in Case of Emergency: _____
Name: _____ Phone: _____

Primary Insurance Information:

Medical Insurance? YES
Policy ID: _____ Group ID: _____
Insurance: _____ Address: _____
Phone: _____
Insured _____ Relationship: _____

Secondary Insurance Information:

Policy ID: _____ Group ID: _____
Insurance: _____ Address: _____
Phone: _____
Insured _____ Relationship _____

I am aware that my account and knowledge of benefits is my responsibility. Foot Specialist Associates, PC cannot guarantee payment, benefits or coverage from my insurance company. I authorize my insurance benefits to be paid directly to Foot Specialist Associates, PC. I authorize the facility to release medical information for treatment, payment or daily operations. I voluntarily consent to examination and treatment for myself or the above dependent patient. I will inform Foot Specialist Associates, PC immediately of any insurance or personal information changes. All unpaid personal balances over 30 days are charged a minimum \$5 fee or 1.5% interest per month. I have read all the above information and asked any necessary questions. I understand my obligations as outlined by this release.

SIGNATURE: _____ DATE: _____

Medical History

Denver

Describe your foot problem:

Past Medical History:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Bowel disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Frequent infections |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Gout | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Peripheral vascular | <input type="checkbox"/> Polio | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Skin disease | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> TB | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Venereal diseases | <input type="checkbox"/> Other | | |

Allergies - check all that apply:

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Adhesive/tapes | <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Iodine | <input type="checkbox"/> Mercurials | <input type="checkbox"/> Merthiolates |
| <input type="checkbox"/> Mycins/other | <input type="checkbox"/> Novocain | <input type="checkbox"/> Nylon/plastics | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Tetanus antitoxin, | | |

Other:

Current Medications. Please list any prescriptions, over-the-counter, and vitamins:

When was your last tetanus shot?

Have you ever had a blood transfusion: Yes No

Is there any chance that you might be pregnant? Yes No

HABITS

Smoking: No. packs per day

How long?

Alcohol: Daily amount

Caffeine: Daily amount

Surgical History: (Please list operations and year)

Injuries (fractures, sprains, other). Please list injury and year:

Family History (please check all that apply)

Heart Disease:	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
High Blood Pressure:	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
Stroke:	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
Cancer:	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
Glaucoma:	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
Diabetes:	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
Epilepsy/convulsion:	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
Bleeding Disorder:	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
Kidney Disease:	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
Thyroid disease:	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
Mental illness:	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
Osteoporosis:	<input type="checkbox"/> Mother	<input type="checkbox"/> Father

Agreement/Conditions of Treatment

I understand my physician will use their best skill and judgement to accomplish the desired result.

I understand physician cannot or does not warrant or guarantee such results.

Their forecast of the length of time involved in therapy/recovery is based on similar cases as mine.

My result or response may be different from the usual.

On my part, I promise full cooperation in my treatment, whether by surgical or nonsurgical means.

I understand if I don't follow instructions, it could jeopardize the outcome and cause a bad result

Patient Signature: _____

Date: _____