



# Patient History Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  MALE  FEMALE Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ Marital Status:  M  S  W  D Spouse's Name: \_\_\_\_\_

**PRIMARY DOCTOR:** \_\_\_\_\_ **Date Last Seen:** \_\_\_\_\_

**Doctor's Phone Number:** \_\_\_\_\_ **How did you hear about us?** \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_ **Pharmacy Phone:** \_\_\_\_\_

Reason for your visit today: \_\_\_\_\_

**Medications** you're currently taking:

Do You Have Any **Allergies**? Please list:

Please list any **recent** surgery or hospitalizations:

Please tell us if you are currently or have in the past had any problems with the following: (please check)

- Significant **weight loss, weight gain, or fatigue?**  Yes  No
- Eyes, ears, nose, mouth or throat** including recent sore or strep throat?  Yes  No
- Heart** including chest pain, **high blood pressure** or **high cholesterol?**  Yes  No
- Blood flow** including problems with **veins, arteries, or bleeding?**  Yes  No
- Lungs** or breathing including asthma, pneumonia or bronchitis?  Yes  No
- Stomach** or intestinal problems including ulcers, heartburn?  Yes  No
- Kidneys** or difficulties going to the bathroom or **frequent urination?**  Yes  No
- Arthritis** or muscle weakness?  Yes  No
- Skin** problems including rash, infections, tumors or psoriasis?  Yes  No
- Frequent **Headaches**, Tingling, Numbness, or burning?  Yes  No
- Anxiety, depression, or other **psychiatric problems?**  Yes  No
- Diabetes?**  Yes  No
- Thyroid** problems or **liver** problems including hepatitis?  Yes  No
- AIDS, HIV, Immunologic Problems?**  Yes  No
- Have or do you **Smoke, Chew Tobacco, Drink Alcohol, or use Drugs?**  Yes  No



I hereby give my permission for physicians of The Foot Group, LLC to examine and administer treatment, after consultation, and perform such procedures as may be necessary in the diagnosis and/or treatment of my foot condition. I hereby authorize the above-mentioned group to bill and receive payment from my insurance company upon receipt of the above-mentioned doctor's itemized statement for services. I authorize that release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. Insurance Coverage and Charges vary according to the type and extent of services rendered. We will be happy to assist you in obtaining reimbursement from your insurance carrier, but in case of claim denial, payment is the patient's responsibility.

**If you miss an appointment a \$25 fee will be assessed to your account.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Patient/Parent/Conservator/Guardian)



## Acknowledgement Receipt of Notice of Privacy Practices

### PATIENT ACKNOWLEDGEMENT

I acknowledge that I have been given the opportunity; to review a copy of *Notice of Privacy Practices* of The Foot Group LLC. I understand that the Notice describes the uses and disclosures of my protected health information, which also informs me of my rights to respect my protected health information.

Patient Name: \_\_\_\_\_  
(Please Print)

Signature: \_\_\_\_\_  
(Patient/Parent/Conservator/Guardian)

Date: \_\_\_\_\_

