Pioneer Foot Care


www.pioneerfootcare.com

**What is bringing you into Pioneer Foot Care today:_____

_____

**We would like to know a little more about you:**

Name: _____ Date of Birth: _____

Sex M/F Social Security # _____ Marital Status: _____

Address:_____City/State_____Zipcode:_____

Home phone:_____ Cell number:_____

Work number _____ Email address: _____

Emergency Contact: _____ Phone#:_____

Relation:_____

Primary Care Physician:_____ Phone #:_____

Pharmacy Name/Location: _____

Primary Insurance Company :_____(please present cards to staff)

ID#:_____ Group#:_____

Secondary Insurance Company: _____

ID#:_____ Group#: _____

***(If Patient is a minor, please name of parent or guardian who is responsible for financial and medical decisions)***

*Name of Parent/Guardian* _____ *Phone #:*_____

*The following people may bring minor to appointment and make medical decisions/ appointments:* _____ *Parent Int*_____

## MEDICAL HISTORY

- ☐ Corn/ calluses
- ☐ Fungal Nails
- ☐ Leg/ Foot Ulcers
- ☐ Broken Foot/ Bone
- ☐ Hammer/ Mallet Toe
- ☐ Arch Pain
- ☐ Lower back pain
- ☐ In-Toeing
- ☐ Warts
- ☐ Ingrown Nails
- ☐ Foot Numbness
- ☐ Broken Ankle
- ☐ Leg/ Foot Cramp
- ☐ High Arch Feet
- ☐ Heel Pain
- ☐ Toe Walking
- ☐ Athlete's Foot
- ☐ Neuroma
- ☐ Bunions
- ☐ Ankle Sprain
- ☐ Flat Feet
- ☐ Knee pain
- ☐ Rash
- ☐ Gout Problems

## Family History

- ☐ Diabetes
- ☐ Arthritis
- ☐ Stroke
- ☐ Cancer
- ☐ Foot Problems
- ☐ Heart attack
- ☐ High Blood Pressure
- ☐ Birth Defects

- ☐ Do you smoke?
- ☐ How much?
- ☐ Did you ever smoke?
- ☐ When did you quit?
- ☐ Recreational drugs?
- ☐ Are you pregnant?

## Patient Medical History

- ☐ Stroke
- ☐ Heart Attack
- ☐ High blood pressure
- ☐ Phlebitis
- ☐ Vascular Disease
- ☐ Heart Condition
- ☐ Anemia
- ☐ Poor Circulation
- ☐ Eyes: Glaucoma
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Keloid/ thick scar
- ☐ Gout
- ☐ Alzheimer's
- ☐ Osteoporosis
- ☐ Sciatica
- ☐ Lyme Disease
- ☐ Rheumatic Fever
- ☐ Arthritis
- ☐ RA
- ☐ Hearing/ Ear disorder
- ☐ Epilepsy
- ☐ Nerve Disorder
- ☐ Psychiatric Disorder
- ☐ Asthma
- ☐ Lung Disease
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Thyroid Problem
- ☐ Cancer
- ☐ None of the above

## SURGICAL HISTORY

## Medications

Please List:

* You can give list to staff

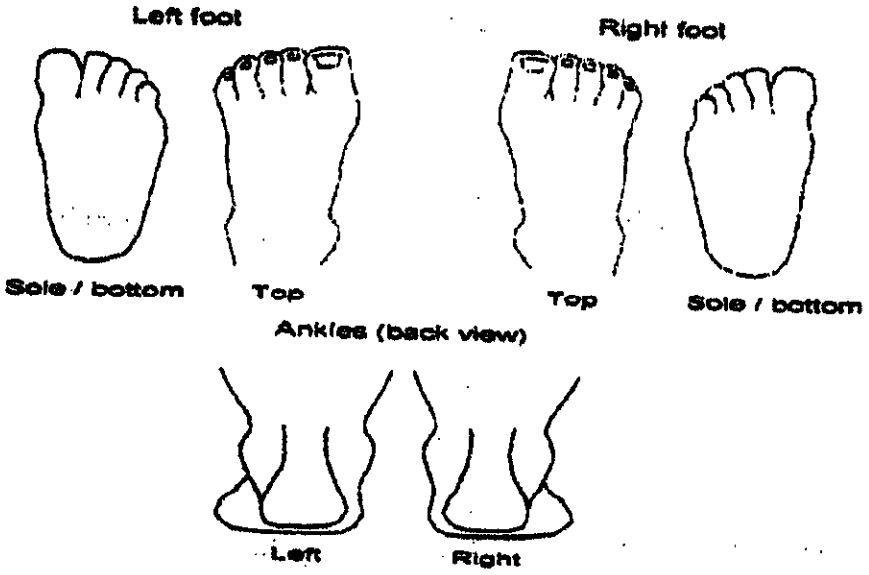
☐ Are you taking INSULIN?

## ALLERGIES

- ☐ Latex
- ☐ Aspirin, Advil, Aleve,Motrin
- ☐ Codeine
- ☐ Novocaine
- ☐ Sulfa Drugs
- ☐ Penicillin
- ☐ Tylenol
- ☐ Celebrex
- ☐ Morphine
- ☐ Other Narcotics
- ☐ Other Anesthetics
- ☐ Shrimp, Iodine or Merthiolate

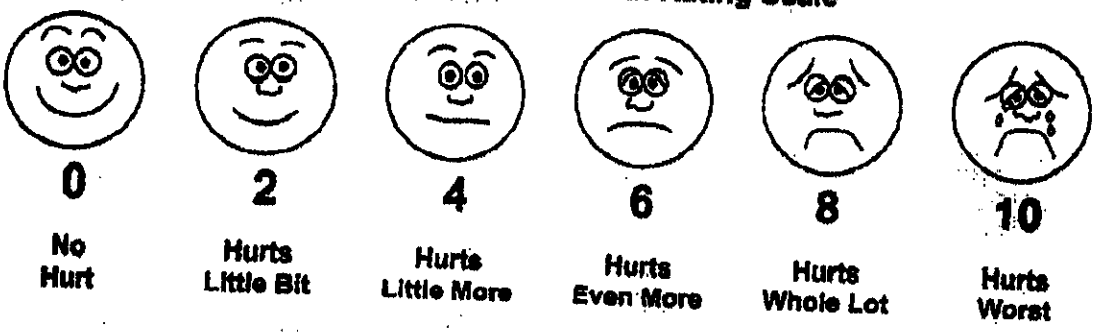
List any other allergies:

**Circle or put an X on where it is hurting you:**




**Circle the pain level you are having**

**Wong-Baker FACES® Pain Rating Scale**




When did this start? _____

What is your occupation: _____

Is this work related? Yes No

How did you hear about us? Friend_____ Physician_____ Website_____Internet_____

Any problems with Anesthesia? _____


**Consent For Care:** I hereby give my consent for treatment for Pioneer Foot Care Staff including treatment or services and which may include but not limited to examination, x-rays, injections, photos and treatments which my physicians and I agree are necessary.

**Authorization to Obtain/Release Medical Records:** I authorize Pioneer Foot Care, or any person designated by them, to obtain/release copies of my medical records to any physician or institution for the purpose of evaluation and/or comparison with examination and testing being performed on myself/my dependent.

**Authorization to Pay Benefits to Physician:** I hereby authorize payment to Pioneer Foot Care for services rendered to me or my dependents. I also authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for any balances not covered by insurance and/or collections costs and legal fees incurred in any attempt to collect said balance. I assign all medical or surgical benefits to Pioneer Foot Care.

**Message Authorization:** I hereby authorize Pioneer Foot Care to message me regarding pending appointments, tests, lab results, matters relating to prescriptions by messaging using the following ( Check all that applies)

_____answering machine/home voice mail
_____With spouse/Family member (Please Specify) _____
_____Receive SMS mobile text reminders and messaging

_____Receive Email messaging and reminders

I have been given an opportunity to read the Health Insurance Portability and Accountability Act 1996 (HIPPA)

**Patient Signature:** _____ **Date:**_____