What is bringing you to Pioneer Foot Care today?

_____

_____

Name: _____ **Date of Birth:** _____ / _____ / _____

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

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email Address:** _____

Emergency Contact: _____

Relation: _____ **Phone Number:** _____

Primary Care Physician: _____ **Phone Number:** _____

Pharmacy Name: _____ **Phone Number:** _____

Pharmacy Location: _____

Primary Insurance Company: _____

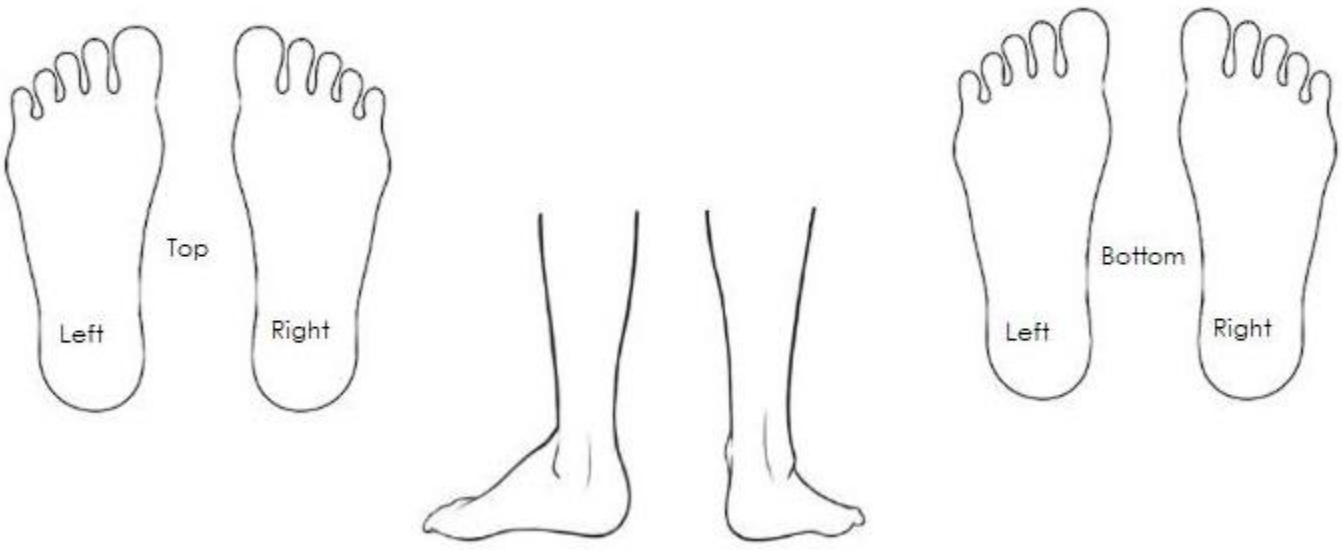
ID #: _____ **Group #:** _____

Secondary Insurance Company: _____

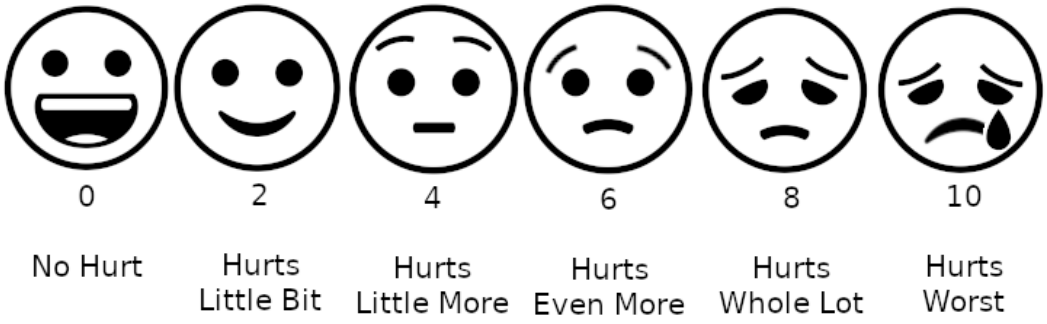
ID #: _____ **Group #:** _____

****Please Present Insurance Cards At Time Of Appointment****

Please indicate where you are having pain by "Circling" the problem area in the diagram below:



Please "Circle" the pain level you are experiencing:



When did this start? _____

What is your occupation? _____

Is this work related? Yes / No If yes, please provide Claim Number: _____

How did you hear about us? Friend _____ **Physician** _____ **Internet** _____

MEDICAL HISTORY

Do you smoke? Yes / No / Previous Smoker (MM ___ / YYYY_____) **If yes, how much?** _____

Do you Vape? Yes / No **Do you use recreational drugs?** Yes / No

Are you pregnant? Yes / No **Are you taking insulin?** Yes / No

Any Implanted Devices? Yes / No **If yes, what type of device?** _____

Any problems with Anesthesia? Yes / No **If yes, what was the reaction?** _____

Please "Check" all that applies:

- o Corns
- o Calluses
- o Fungal Nails
- o Leg / Foot Ulcers
- o Broken Foot / Ankle
- o Hammer / Mallet Toe
- o Arch Pain
- o Lower Back Pain
- o In -Toeing
- o Warts
- o Ingrown Nails
- o Foot Numbness
- o Leg / Foot Cramp
- o High Arch Feet
- o Heel Pain
- o Toe Walking
- o Athlete's Foot
- o Neuroma
- o Bunions
- o Ankle Sprain
- o Flat Feet
- o Knee Pain
- o Rash
- o Gout
- o Stroke
- o Heart Attack
- o High Blood Pressure
- o Phlebitis
- o Vascular Disease
- o Heart Condition
- o Anemia
- o Poor Circulation
- o Glaucoma
- o Diabetes
- o Kidney Disease
- o Keloid
- o Alzheimer's
- o Osteoporosis
- o Sciatica
- o Lyme Disease
- o Rheumatic Fever
- o Arthritis
- o RA
- o Hearing / Ear Disorder
- o Epilepsy
- o Nerve Disorder
- o Psychiatric Disorder
- o Asthma
- o Lung Disease
- o Tuberculosis
- o Hepatitis (Type: _____)
- o Liver Disease
- o Thyroid Problem
- o Cancer

FAMILY HISTORY

- o Diabetes
- o Arthritis
- o Stroke
- o Cancer
- o Foot Problems
- o Heart Attack
- o High Blood Pressure
- o Birth Defects

SURGICAL HISTORY

- o _____
- o _____
- o _____
- o _____
- o _____

MEDICATIONS

Please list below or provide a list of your own including dosages:

- o _____
- o _____
- o _____
- o _____
- o _____
- o _____
- o _____
- o _____
- o _____
- o _____
- o _____
- o _____
- o _____
- o _____

ALLERGIES

- o Latex
- o Aspirin, Advil, Aleve, Motrin, Tylenol
- o Codeine
- o Sulfa Drugs
- o Penicillin
- o Celebrex
- o Morphine
- o Novocain
- o Narcotics
- o Anesthetics
- o Shrimp, Iodine, Merthiolate
- o Other: _____ _____

Consent to Care: I hereby give consent for treatment or services to Pioneer Foot Care and all Podiatrist Residents / Students. Treatment and services may include, but are not limited to, Examination, X-Rays, Injections, Photos, and any 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 purposes of evaluation and / or comparison with examination and testing being performed on myself / dependent.

Authorization to Pay Benefits to Physician: I authorize payment to Pioneer Foot Care for services rendered to me or my dependent(s). I also Authorize Pioneer Foot Care 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 insured in any attempt to collect said balances. I assign all medical or surgical benefits to Pioneer Foot Care.

Message Authorization: I authorize Pioneer Foot Care to contact me regarding Appointments, Tests, Lab Results, and matters relating to prescriptions by messaging using the following: (Please Check all that Apply)

_____ Answering Machine / Voicemail

_____ With Spouse / Family Member: (Please Indicate Who) _____

_____ Receive Mobile Text Reminders / Messaging

_____ Receive Email Reminders

I have been given the opportunity to read the Health Insurance Policy and Accountability Act of 1996 (HIPAA)

Signature: _____ **Date:** _____ / _____ / _____

If Patient is a Minor, please provide name of Parent / Guardian who is responsible for Financial / Medical decisions

Name: _____ **Phone Number:** _____

The following people may bring Minor to appointments and make Medical Decisions / Appointments

Name(s): _____ , _____ , _____