

WELCOME TO OUR OFFICE

TODAY'S DATE: _____

In order to serve you better, we need the following information.
All information is strictly confidential.

How did you hear about us? _____

Patient's Name _____ Birthdate: _____
(Last) (First) (Middle) (Month, Day, Year)

SSN: _____ Sex: M F Height _____ Weight _____ Shoe Size _____

Address _____ City _____ Zip Code _____

Home Phone(____) _____ Work Phone _____ Cell _____

Name of Spouse/Parent/Sig. Other _____ Marital Status: M S D W SEP

Chief Complaint/Reason for visit: _____

How long has this bothered you? _____ What have you done to treat the problem? _____

Do you currently wear orthotics? Yes _____ No _____ Do you have arch support problems? Yes _____ No _____

Ingrown toenails? Yes/No Diabetic? Yes/ No _____ Do you take insulin? Yes/No # of years _____ Last glucose # _____

Family Physician: _____ Date last seen _____ Phone # _____ May we contact? _____

Pharmacy: _____ Phone # _____ Current Conditions you are being treated for: _____

CIRCLE ALLERGIES TO MEDICINES OR FOODS IF ANY:

Adhesive Tape Dairy Products Aspirin Penicillin Wool Seafood Codeine
Sulfa Drugs Nylon Vegetables Local Anesthetics Metals **NO ALLERGIES**
Other Allergies: _____ What type of reaction do you have? _____

Please list all hospitalizations/surgeries you have had _____

List any medications you are taking, even over the counter (if you have a list please give to receptionist and skip this question)

CIRCLE ANY CONDITIONS YOU HAVE (OR HAVE HAD IN THE PAST):

Asthma Calf Pain Hepatitis Nerve problems
Arthritis Cancer GI Disorders Phlebitis
Anemia Gout Mononucleosis Rheumatism
Bleeding Problems Eye Disease Neck Stiffness Skin Problems
Broken Bones Hearing Problems

FAMILY HISTORY

Mother: Living _____ Deceased _____ Cause of death _____

Father: Living _____ Deceased _____ Cause of death _____

Siblings: Living _____ Deceased _____ Cause of death _____

IS THERE A FAMILY HISTORY OF ANY OF THE FOLLOWING (CIRCLE)

Heart Disease Arthritis Stroke Bleeding Disorder Bunions
Hammertoes Flatfeet Diabetes Gout Circulation Problems

SOCIAL HISTORY: Which of the following best describes your lifestyle (circle all that apply):

Athletic/What type of sport? _____ Drink Alcohol? Yes No How much? _____ Coffee/Tea

Smoker-now _____ Quit _____ Yrs ago _____ How many packs? _____ Recreational drug use _____

Occupation: _____ Do you stand? Yes No Sit: Yes No Both Employer's Name: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT/FINANCIAL AGREEMENT

I HEREBY AUTHORIZE CONNIE L. BILLS, D.P.M., TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS AN INSURANCE CLAIM AND FUTURE AUTHORIZE PAYMENT DIRECTLY TO THIS PHYSICIAN FOR ANY SERVICES RENDERED AND NOT PAID FOR BY ME. **NOTICE: ROUTINE CARE OF TOENAILS, CORNS AND CALLUSES ARE NOT A MEDICARE COVERED SERVICE.** ANY CO-PAYMENTS OR DEDUCTIBLES ARE PAYABLE AT THE TIME OF VISIT. I UNDERSTAND THERE IS NO GUARANTEE THAT MY INSURANCE COMPANY WILL PAY FOR MY OFFICE VISIT OR ANY MEDICAL SUPPLIES THAT MAY BE SUPPLIED. IF I AM BILLED FOR ANY AMOUNT MY INSURANCE DOES NOT COVER, I UNDERSTAND THE FULL AMOUNT IS DUE WITHIN 30 DAYS UNLESS PAYMENT ARRANGEMENTS ARE MADE WITH THIS OFFICE. IF PAYMENT IS NOT RECEIVED, THIS OFFICE WILL TAKE NECESSARY MEASURES FOR COLLECTION AND A 33% FEE RELATED TO THE COLLECTION OF MONIES WILL BE ADDED TO THE AMOUNT PAYABLE. YOU MUST GIVE THIS OFFICE 24 HOURS NOTICE OF CANCELLATIONS OF APPOINTMENTS, OR A \$ 50.00 CHARGE WILL BE BILLED TO YOU.

SIGNATURE OF PATIENT OR GUARDIAN

DATE