

Patient Information

Last Name: _____ Home Phone: _____
First Name: _____ MI _____ Work Phone: _____
Address: _____ Cell Phone: _____
City: _____ State: _____ Email: _____
Zip: _____ Sex (M/F) _____ Date of Birth: _____ Age: _____
Employer: _____ Social Security #: _____
Job Title: _____ Status: (S) (M) (D) (W)

Emergency Information

Primary Care Physician: _____ Name emergency contact: _____
Phone: _____ Phone: _____

Insurance

Primary Ins Co: _____ Secondary Ins Co: _____
Ins ID#: _____ Ins ID#: _____
Policy Holder's Name: _____ Policy Holder's Name: _____

Allergies:

- tape
- shellfish/iodine
- latex
- lidocaine
- penicillin
- sulfa
- _____
- _____
- _____

Medications:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Insurance Policy: If Charlotte Foot & Ankle is contracted with your insurance company and your visit is for a covered service, then we will file a claim for you. We will also collect any copay, coinsurance, and deductible at the time of service. If we are **not** contracted with you insurance company or your visit includes non-covered services, you are responsible for payment on the day of service. For your convenience we accept cash, checks, Mastercard and Visa.

What is the reason that brought you to our office: _____

How long has it bothered you? _____

What has made the pain go away? _____

Whom may we thank for referring you? _____

Review of Systems

- | | | |
|--|--|---|
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Skin problems | <input type="checkbox"/> Hyperglycemia |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Ankle or foot edema | <input type="checkbox"/> Loss of sensation |
| <input type="checkbox"/> Fever, nausea, or dizziness | <input type="checkbox"/> Burning feet | <input type="checkbox"/> Nail changes |
| <input type="checkbox"/> Eye problems | <input type="checkbox"/> Calf pain | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> GI symptoms | <input type="checkbox"/> Change in thirst/appetite | <input type="checkbox"/> Foot color changes |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Skin color - redness |
| <input type="checkbox"/> Neurological symptoms | <input type="checkbox"/> Hair loss | <input type="checkbox"/> thin skin |
| | | <input type="checkbox"/> Foot tingling |

Past Medical History

- | | | |
|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bleeding problems/Clotting | <input type="checkbox"/> Congestive heart failure |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Fungal infections | <input type="checkbox"/> Gout | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Back pain or injury | <input type="checkbox"/> _____ |

Hospitalizations

Surgeries

Are you pregnant? (Y) (N)

Do you smoke? (Y) (N)

How many packs per day? _____

How many years? _____

What is your height? _____ What is your weight? _____ What is your shoe size? _____

How did you here about us? ___ newspaper ___ yellow pages ___ internet

___ other (_____)