AFFILIATED FOOT AND ANKLE CENTER, LLP

Patient: ____ Date________________________
(Full name)
Street: ______________________________________ City: _____________ State: _____ Zip: _____________

Home Phone: (______) _____________________ Date of Birth: ____________________ Age: ____________

E-mail address (will not be shared in any way): ____

Sex: __M __F Occupation: ________________________________ Cellular #: (____)_________________

Employer: ____ Work Phone: (_____) __________________

Business Address: ____

Spouse's Full Name: ___________________________________ Occupation: __________________________

Your Pharmacy: __________________________ Town: ________________ Phone #: ___________________

Emergency Contact - Name: __________________________________ Phone: (_____) __________________

♦♦

SS#: ___________________________ Medicare #: ____

Primary Ins. Co.: ____ Policy #: ________________________

Name of Insured: _____________________________________ Group #: ______________________________

Soc. Sec. # of Insured: ________________ D.O.B of Insured: ____/____/____ Relationship: _____________

Secondary Ins. Co.: ____ Policy #: ______________________

Name of Insured: ____________________________________ Group #: _______________________________

Soc. Sec. # of Insured: _________________ D.O.B of Insured: ____/____/____ Relationship: ____________

Referred by: ________________________ Date of Last Physical : _________ By Whom: _______________

Family M.D. _______________________ Address: ____

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What is your foot problem(s): ____

____

Shoe Size: __________Have you ever worn custom made arch supports (orthotics) ___Y ___N Do you smoke? ___Y___N

Illnesses: (Check those which apply):
____Poor Circulation ____Heart Disease ____ Liver Disease ____Diabetes ____Arthritis ____Anemia ____Kidney Problem ____Hepatitis ____Lung Problems ____Back Problems ____Bleeding Disorders ____Asthma ____ Gout ____ High Blood Pressure ____Rheumatic Fever ____Stroke _____Back Pain _____Neck Pain ____ Numbness in Feet

Allergies to Medications: (Check those which apply):
____Penicillin ____Aspirin ____Codeine Adhesive Tape ____Iodine
____Sulpha ____Sea Food ____Local Anesthetic ____Other: ____________________________

Medication Taking: (Prescription and non-prescription) ____
____
____
____

Prior Surgery or Illnesses: ____
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____
____
____

I hereby give my permission to the doctors at Affiliated Foot and Ankle Center, LLP to perform diagnostic, therapeutic and/or operative procedures as may be deemed necessary in diagnosis and/or treatment of my feet and/or ankles.

PATIENT SIGNATURE: ____ DATE: __________________