CONNECTICUT FOOT CARE CENTERS

PATIENT INFORMATION

(PLEASE PRINT)

NAME______________________________MI______DATE______________

ADDRESS______________________CITY/STATE______________ZIP______

HOME PHONE (____)______________SOCIAL SEC #______________SEX: M F

DATE OF BIRTH______________AGE________MARITAL STATUS S M D W SEP

CELL PHONE (____)______________EMAIL ADDRESS______________________

REFERRED BY____

EMERGENCY CONTACT______________PHONE______________RELATIONSHIP________

PATIENT'S EMPLOYER____

BUSINESS ADDRESS______________________BUS. PHONE (____)________EXT____

SPOUSE'S NAME______________SPOUSE'S DATE OF BIRTH__________BUS. PHONE (____)______

SPOUSE'S EMPLOYER______________________EMPLOYER ADDRESS______________________

PERSON RESPONSIBLE FOR BILL

(IF OTHER THAN ABOVE)

NAME______________________________RELATIONSHIP______________

ADDRESS______________________________HOME PHONE (____)__________

EMPLOYER______________________________BUS. PHONE (____)__________

DATE OF BIRTH______________________SOCIAL SEC. #______________________

INSURANCE INFORMATION

COMPANY OR PROGRAM	INSURED'S NAME	INSURED'S SOC. SEC.#	GROUP #	POLICY #
1)				
2)				

AUTHORIZATIONS

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS ANY CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT OR OTHER BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I UNDERSTAND I AM RESPONSIBLE FOR ANY PORTION OF MY BILL NOT COVERED BY MY INSURANCE COMPANY

I UNDERSTAND ALL OF THE ABOVE AND HEREBY STATE THAT THE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

DATE______________ SIGNED______________________________

(RESPONSIBLE/INSURED PERSON)

MEDICAL INFORMATION

NAME OF PRIMARY CARE PHYSICIAN ____________________

LIST PHYSICIANS CURRENTLY TREATING YOU ____________________

DESCRIBE YOUR CURRENT FOOT PROBLEM(S) ____________________

HOW LONG HAS IT BEEN BOTHERING YOU? ____________________

SHOE SIZE ____________ CURRENT WEIGHT ____________ HEIGHT ____________

LIST CURRENT MEDICATIONS ____________________

DO YOU TAKE ASPIRIN? ____________ BIRTH CONTROL PILLS ____________

DO YOU SMOKE CIGARETTES? YES NO DAILY AMOUNT ____________

DO YOU DRINK ALCOHOL? YES NO DAILY AMOUNT ____________

ARE YOU ALLERGIC TO?: MEDICATIONS ____________________

TAPE ____________ BETADINE(IODINE) ____________ OTHER ____________

HAVE YOU HAD PROBLEMS TAKING ASPIRIN? ____________ IBUPROFEN(ADVIL OR MOTRIN) ____________

ANY PROBLEMS WITH LOCAL ANESTHETICS? ____________ GENERAL ANESTHESIA? ____________

LIST ALL PAST HOSPITALIZATIONS OR SURGERY: ____________________

CHECK ANY OF THE FOLLOWING THAT YOU HAVE , OR HAVE HAD A PROBLEM WITH:

() HEART	() THYROID	() TUBERCULOSIS	() RHEUMATIC FEVER
() DIABETES	() LIVER	() ULCERS	() LUNGS
() ASTHMA	() KIDNEY	() GERD	() ARTHRITIS/BURSITIS
() HEPATITIS	() ANEMIA	() GLAUCOMA	() LYME DISEASE
() CIRCULATION	() GOUT	() BACK PAIN	() FIBROMYALGIA
() RAYNAUD'S	() HIV/AIDS	() HIGH BLOOD PRESSURE	() AUTO IMMUNE DISEASE
() STROKE	() EPILEPSY	() PHLEBITIS	() DRUG/ALCOHOL ABUSE
() CANCER	() CHOLESTEROL	() OTHER ____________	

DO YOU HAVE ANY ARTIFICIAL JOINTS? YES NO HIP? KNEE? OTHER

IS THERE A FAMILY (BLOOD RELATIVE) HISTORY OF:

() HEART DISEASE	() CIRCULATION PROBLEMS	() BLEEDING DISORDER
() DIABETES	() STROKE	() NERVE DISORDER
() ARTHRITIS	() HIGH BLOOD PRESSURE	() CANCER

IS THERE ANY OTHER GENERAL OR FOOT HEALTH INFORMATION THAT WE SHOULD KNOW? ____________________

TO OUR FEMALE PATIENTS: ARE YOU PREGNANT? YES NO POSSIBLE

NEUROLOGIC EXAM

	PATELLAR	ACHILLES	SHARP/DULL	VIBRATION	5.07 MONO
RIGHT					
LEFT					

	Right Extremity			Left Extremity		
Dorsalis Pedis Pulse	❑ Palpable	❑ Non-Palpable		❑ Palpable	❑ Non-Palpable	
Posterior Tibial Pulse	❑ Palpable	❑ Non-Palpable		❑ Palpable	❑ Non-Palpable	
Pigmentary Change	❑ Rubor	❑ Cyanosis	❑ Pallor	❑ Rubor	❑ Cyanosis	❑ Pallor
Hair Growth	❑ Normal	❑ Sparse	❑ Absent	❑ Normal	❑ Sparse	❑ Absent
Edema	❑ None	❑ Pitting	❑ Non-Pitting	❑ None	❑ Pitting	❑ Non-Pitting
Digital Cooling	❑ Normal	❑ Excessive		❑ Normal	❑ Excessive