CONNECTICUT FOOT CARE CENTERS

PATIENT INFORMATION

FIRST NAME: _____ **MIDDLE INITIAL**: _____ **LAST NAME**: _____

SSN: _____ **BIRTHDATE (MM/DD/YYYY)**: _____/_____/_____ **AGE:** _____ **GENDER**: ☐Male ☐Female

STREET ADDRESS: _____

CITY: _____ **STATE**: _____ **ZIP**: _____ **EMAIL**: _____

HOME PHONE: (_____)_____-_____ **WORK PHONE**: (_____)_____-_____ **CELL PHONE**: (_____)_____-_____

CONTACT PREFERENCES (What way(s) can we contact you?): ☐Phone ☐Mail ☐E-Mail

PRIMARY CARE PHYSICIAN: _____**DATE OF LAST VISIT:**_____/_____/_____**CITY**: _____

OTHER PHYSICIANS CURRENTLY TREATING YOU: _____

WERE YOU REFERRED TO OUR OFFICE? : ☐Yes ☐No **IF YES, WHO REFERRED YOU? :**_____

EMERGENCY CONTACT: _____ **PHONE:** (_____)_____-_____ **RELATIONSHIP:** _____

PRIMARY LANGUAGE*: ☐English ☐Other: _____

RACE*: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White

ETHNICITY*: ☐Hispanic or Latino ☐Not Hispanic

MARITAL STATUS: ☐Single ☐Married ☐Divorced ☐Widowed ☐Partner

STUDENT STATUS: ☐Full Time ☐Part Time ☐Not a Student

EMPLOYMENT STATUS: ☐Full Time ☐Part Time ☐Not Employed

PATIENT'S EMPLOYER: _____ **STREET ADDRESS:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE:		**SECONDARY INSURANCE:**	
Insurance Company		**Insurance Company**	
Insurance ID #		**Insurance ID #**	
Group #		**Group#**	
Subscriber's Name		**Subscriber's Name**	
Subscriber's Birthdate	/ /	**Subscriber's Birthdate**	/ /
Relationship to Subscriber		**Relationship to Subscriber**	
Effective Date	/ /	**Effective Date**	/ /
Subscriber's Employer		**Subscriber's Employer**	

RESPONSIBLE PARTY (if other than patient)

NAME: _____ **BIRTHDATE:**_____/_____/_____ **PHONE**: (_____)_____-_____

ADDRESS: _____**CITY:** _____**STATE:** _____ **ZIP:** _____

AUTHORIZATION

I authorize the release of any medical or other information necessary to process any claims.

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.

PATIENT/RESPONSIBLE PARTY'S SIGNATURE: _____ **DATE**:_____/_____/_____

***Required by the U.S. Federal Government under the Patient Protection and Affordable Care Act.**

MEDICAL INFORMATION

CURRENT FOOT PROBLEM: _____

_____

DURATION OF CURRENT FOOT PROBLEM: _____ ☐Days ☐Month(s) ☐Year(s)

HEIGHT: _____ **WEIGHT:** _____ **SHOE SIZE:** _____ **TYPE OF SHOES WORN:** ☐Flats ☐Heels ☐Sneakers ☐Work Boots

PREFERRED PHARMACY: _____ **LOCATION**: _____

LIST CURRENT MEDICATIONS: _____

_____

MEDICATION ALLERGIES (NAME/REACTION)? : _____

ARE YOU ALLERGIC TO? : ☐Adhesives ☐Aspirin ☐Betadine (Iodine) ☐Ibuprofen (Advil or Motrin) ☐Latex ☐No Allergies

DO YOU HAVE PROBLEMS WITH? : ☐General Anesthesia ☐Local Anesthetics ☐No Known Issues

DO YOU SMOKE CIGARETTES? : ☐Yes ☐No AMOUNT: _____ **DO YOU DRINK ALCOHOL? :** ☐Yes ☐No AMOUNT: _____

TO OUR FEMALE PATIENTS - DO YOU TAKE BIRTH CONTROL PILLS? : ☐Yes ☐No **ARE YOU PREGNANT? :** ☐Yes ☐No ☐Possibly

PAST SURGERY/HOSPITALIZATION(S): _____

_____

MEDICAL HISTORY **(PLEASE INDICATE IF *YOU* HAVE A HISTORY OF THE FOLLOWING)**:

☐Alcohol/Drug Abuse _____
☐Alzheimer's/Dementia_____
☐Anemia _____
☐Artificial Joints _____
☐Arthritis _____
☐Asthma _____
☐Autoimmune Disease _____
☐Back Pain _____
☐Birth Defects _____
☐Bleeding Disease _____
☐Blood Clots _____
☐Blood Transfusion(s) _____
☐Cancer _____
☐Diabetes_____
☐Epilepsy _____
☐Fibromyalgia _____
☐Gout _____
☐Growth/Development Disorder
☐Heart Attack _____
☐Heart Disease _____
☐Hepatitis A, B or C _____
☐High Blood Pressure _____
☐High Cholesterol _____
☐HIV/AIDS _____
☐Kidney Disease _____
☐Liver Disease _____
☐Lung/Respiratory Disease
☐Lyme Disease _____
☐Mental Illness _____
☐Migraines _____
☐Osteoporosis _____
☐Phlebitis _____
☐Raynaud's Disease ____
☐Reflux/GERD _____
☐Stroke/CVA _____
☐Tuberculosis _____
☐Thyroid Problems _____
☐Ulcer(s) _____
☐Other_____
☐NONE of the Above

FAMILY MEDICAL HISTORY **(PLEASE INDICATE IF *YOUR FAMILY* HAS A HISTORY OF THE FOLLOWING)**:

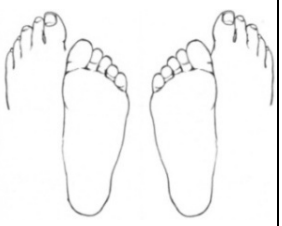
☐Arthritis_____
☐Bleeding Disorder_____
☐Cancer_____
☐ Circulation Problems_____
☐ Diabetes_____
☐Heart Disease_____
☐High Blood Pressure_____
☐Nerve Disorder_____
☐Stroke_____
☐Other_____
_____
☐Family History Unknown

ADDITIONAL MEDICAL HISTORY? _____

_____

***For Internal Use Only*:**

	Left Extremity	Right Extremity
DP Pulse	☐ Palpable ☐ Non-Palpable	☐ Palpable ☐ Non-Palpable
PT Pulse	☐ Palpable ☐ Non-Palpable	☐ Palpable ☐ Non-Palpable
Pigment 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
5.07 Filament	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
	☐Sub 1 ☐Sub 3 ☐Sub 5 ☐Midfoot ☐Heel	☐Sub 1 ☐Sub 3 ☐Sub 5 ☐Midfoot ☐Heel



Left **Right**