Feet First Podiatry – Patient Information Sheet

Patient Information:

Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone #: _____ **Cell Phone #:** _____

Sex: _____**Female** _____**Male** **Marital Status:** ____**Single** ____**Married** ____**Widowed** ____**Divorced**

Social Security #:_____ *(Used only for coordination of benefits by law. We do not share information.)*

Spouse/Partner Name: _____

Employer: _____ **Phone #:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Care Physician: _____ **PCP Phone:** _____

PCP Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Date Last Seen: _____

Referring Physician: _____ **Phone:** _____ **Date Last Seen:** _____

Primary Insurance _____ **Are you the insured?** ____ **Yes** _____**No**

Insured Information: Subscriber Name: _____ Relationship to Patient: _____

Subscriber Phone: _____ Sex: ____Male ____ Female DOB: _____/_____/_____

Subscriber Social Security #:_____ Who is Guarantor? Patient Subscriber Other_____

Address: _____

Policy ID: _____ Group #: _____ Employer: _____

Secondary Insurance: _____ **Are you the insured?** ____**Yes** _____ **No**

Insured Information: Name: _____ Relationship to Patient: _____

Subscriber Phone: _____ Sex: ____ Male ____Female DOB: _____/_____/_____

Address: _____

Policy ID: _____ Group #: _____ Employer: _____

How did you find out about our practice?

☐ Physician ☐ Internet ☐ Telephone Book ☐ Family Member ☐ Friend ☐ Drive By ☐ Other_____

What is the reason for your visit today? _____

How long has this bothered you? 1 2 3 4 5 6 7 more Days Weeks Months Years

What treatments have you tried & have they been effective? _____

_____

On a scale of 1 to 10 (1 being no pain and 10 being the worst), what is your level of pain? _____

The pain quality is:

☐ Burning ☐ Constant ☐ Shooting ☐ Throbbing ☐ Tingling ☐ Dull ☐ Sharp ☐ Other:

Please Read and Sign: **The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.**

Signature: X_____ **Date:** _____