GREEN FOOT & ANKLE CARE, LLC
PATIENT UPDATE

Please Use Blue or Black Ink

Patient Legal Name: _____ Nickname: _____
FIRST MIDDLE INITIAL LAST

Home Phone: (____)_____ Cell Phone: (_____)_____

Address: _____
STREET CITY STATE ZIP

Birth Date: _____/_____/_____ SSN: _____-_____-_____ E-Mail: _____

Sex: Male Female Marital Status: Single Married Widowed Divorced Separated

Race: White Black/African American Other: _____ Ethnicity: Hispanic Not Hispanic Primary Language: _____

Employer: _____ Work Phone: (____)_____

Address: _____
STREET CITY STATE ZIP

Occupation: _____

Responsible Party: _____ Relationship: _____
Home #: (_____)_____Cell #: (_____)_____Work #: (_____)_____
Address: _____
STREET CITY STATE ZIP

Birth Date: _____/_____/_____ SSN: _____-_____-_____ Employer: _____

Do you have a Medical or Financial Power of Attorney? Yes No (If yes, please see note below)

**** If you have a Medical or Financial Power of Attorney, all paperwork must be presented to the office at the time of the appointment. Failure to provide legal documentation may result in the cancellation of the appointment.**

Closest Relative not living with you: _____ Relationship: _____
Home #: (_____)_____Cell #: (_____)_____ Work #: (_____)_____

INSURANCE INFORMATION

PLEASE PRESENT YOUR INSURANCE CARD(S) & DRIVER'S LICENSE TO THE RECEPTIONIST TO COPY

Policy Holder: ☐ Self ☐ Responsible Party (as above)
☐ Other: Complete the following

Primary Insurance: _____
ID #:_____
Group #:_____
Subscriber Name: _____
Subscriber DOB: _____
Subscriber SSN: _____
Subscriber Employer: _____
Subscriber Address: _____
Relationship to Patient: _____

Policy Holder: ☐ Self ☐ Responsible Party (as above)
☐ Other: Complete the following

Secondary Insurance: _____
ID #: _____
Group #: _____
Subscriber Name: _____
Subscriber DOB: _____
Subscriber SSN: _____
Subscriber Employer: _____
Subscriber Address: _____
Relationship to Patient: _____

CONSENT FOR TREATMENT

Must be signed by all patients or guardians prior to being seen by physician

I certify that the information is true and correct to the best of my knowledge. I give my permission to the doctor to examine, photograph, x-ray, administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problems.

_____ _____ _____
Signature of Patient, Parent, Guardian or Personal Representative | Relationship | Date

MEDICAL HISTORY

Please fill out all blanks, use N/A if question does not apply

Patient Legal Name: _____ **Birth Date**: _____/_____/_____

Are you pregnant? _____ Shoe Size: _____ Weight: _____ Height: _____

Past Medical History – Please circle those that apply

AIDS/HIV	Cancer	Gout	Phlebitis
Anemia	Chemical Dependency	Heartburn/Reflux	Psychiatric Care
Arthritis	Circulatory Problems	Hemophilia	Respiratory Disease
Artificial Implants	Diabetes	Hepatitis	Stroke
Back Problems	Epilepsy/Seizures	High Blood Pressure	Swelling in Ankle/Foot
Bleeding Disorder	Fainting	Kidney Problems	Thyroid Disease
Blood Clots/DVT	Foot Ulcers	Liver Disease	Varicose Veins

Any other medical conditions _____

Surgical History, Please list all surgeries _____

_____

Family History, Do you have a family history of the following? Please circle the condition(s) and whether that family member is living or deceased. (Immediate family only). If none, please circle N/A.

Mother:	Diabetes	Heart Disease	Hypertension	Living	Deceased	N/A
Father:	Diabetes	Heart Disease	Hypertension	Living	Deceased	N/A
Brother:	Diabetes	Heart Disease	Hypertension	Living	Deceased	N/A
Sister:	Diabetes	Heart Disease	Hypertension	Living	Deceased	N/A

Social History

Do you use Tobacco? Yes No If yes, how often? _____

Do you Drink Alcohol? Yes No If yes, how often? _____

Allergies - Include allergies to medications, food, etc.

_____

Current Medications - Include both prescription and over the counter medications (Attach list if needed)

_____

_____

Family Doctor: _____

Phone: _____ Date Last Seen: _____

Endocrinologist: _____

Phone: _____ Date Last Seen: _____

Other Doctor: _____ Specialty: _____

Phone: _____ Date Last Seen: _____

Pharmacy: Local: _____ Address: _____ Phone: _____

Mail Order: _____ Address: _____ Phone: _____

May we send you an e-mail? Yes No

Which phone would you prefer the reminder call go to? Home Cell

May we send you a text message: Yes No

Whom may we discuss your medical/financial information with?

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____