

**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: \_\_\_\_\_

**\*\* 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

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 Other: Complete the following

Primary Insurance: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

ID #: \_\_\_\_\_

ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_

Subscriber SSN: \_\_\_\_\_

Subscriber SSN: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_

Subscriber Address: \_\_\_\_\_

Subscriber Address: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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? If yes, please circle family member and whether they are living or deceased.

Diabetes:	Yes	No	Mother	Father	Brother	Sister	Living	Deceased
Heart Disease:	Yes	No	Mother	Father	Brother	Sister	Living	Deceased
Hypertension:	Yes	No	Mother	Father	Brother	Sister	Living	Deceased

### 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:** \_\_\_\_\_

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

Whom may we discuss your medical/financial information with?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_