FUTCH | PODIATRY

145 Hilden Road | Suite 103 | Ponte Vedra, Florida 32081 | 904-615-1853 | 904-615-1873 (fax)

PLEASE PRINT INFORMATION

Full Name_____DOB_____

Address_____City_____State_____Zip_____

Phone (home) _____ (work) _____ (cell) _____

Email Address _____

SSN_____ Sex _____ Race_____

Primary Care Physician_____ Phone_____

Occupation _____ Employer Name_____

Employer Address_____City/State_____Zip_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered

Spouse Name_____ Phone_____

Emergency Contact Name _____Phone_____

Emergency Contact Address _____City/State _____

Relationship to Patient_____

What is the reason for your visit today? _____

How long has this bothered you? _____days _____weeks _____months _____years

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

_____

Current Medications: _____

MEDICAL HISTORY

Have you had any past problems with your feet or ankles? ☐ Yes ☐ No

If yes, please describe:_____

Are you allergic or sensitive to:

☐ Penicillin ☐ Sulfa ☐ Tape ☐ Latex ☐ Betadine (iodine) ☐ Aspirin ☐ Tylenol ☐ Ibuprofen ☐ Vicodin ☐ Codeine
☐ Other (specify)_____ ☐ None of the above

Please indicate if you have a problem with any of the following:
☐ Alcoholism ☐ Blood disorders ☐ Gout ☐ Liver ☐ Sleep apnea ☐ Allergies ☐ Breathing problems ☐ Heart disease ☐ Musculoskeletal ☐ Stomach/bowel ☐ Circulation problems ☐ Heart murmur ☐ Depression/anxiety ☐ High blood pressure ☐ Asthma ☐ Mental illness ☐ High cholesterol ☐ Blood clot/DVT/PE ☐ Diabetes (☐ type 1 / ☐ type 2)
☐ Kidney Problems ☐ Arthritis (specify)_____ ☐ Neurological (specify)_____
☐ Thyroid (specify)_____ ☐ Skin disorders (specify)_____
☐ Other (specify)_____

Are you pregnant? ☐Yes ☐ No **Are you nursing?** ☐Yes ☐ No

(OVER)

Are you disabled? ☐Yes ☐ No **Do you have an artificial heart valve?** ☐ Yes ☐ No

Have you ever had any surgical procedures on your foot/ankle or anywhere else on your body? ☐Yes ☐ No
If yes, please describe:_____

Do you have any artificial joints? ☐ Yes ☐ No If yes, where? _____

FAMILY HISTORY

Is there any family history (blood relative) of:
☐ Arthritis ☐ Cancer ☐ Flatfeet ☐ Bleeding disorders ☐ Circulation problems ☐ Hammer toes
☐ Diabetes ☐ Blood clot/DVT/PE ☐ Heart disease ☐ Bunions ☐ Neurological ☐ Strokes

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No **Did you smoke in the past?** ☐ Yes ☐ No **If yes, for how long?** _____
Do you drink alcohol? ☐ Yes ☐ No **If yes**: ☐ Socially ☐ 1 daily ☐ 2 daily ☐ 2+ daily
Do you stand or sit at work? ☐ Stand ☐ Sit
What athletic activities do you participate in? _____

DO YOU HAVE…

• Tired or achy feet / legs?	**☐ Yes**	**☐ No**	**• "High arch"?**	**☐ Yes**	**☐ No**
• Heel pain?	**☐ Yes**	**☐ No**	**• Toe pain/numbness?**	**☐ Yes**	**☐ No**
• Calluses on your feet/toes?	**☐ Yes**	**☐ No**	**• Knee pain?**	**☐ Yes**	**☐ No**
• Pain at the ball of your foot?	**☐ Yes**	**☐ No**	**• Hip pain?**	**☐ Yes**	**☐ No**
• Uneven footwear?	**☐ Yes**	**☐ No**	**• Lower back pain?**	**☐ Yes**	**☐ No**
• "Flat feet"?	**☐ Yes**	**☐ No**			

If you answered YES to one or more of the above questions, you may be a candidate for Orthotics or Orthopedic Footwear.

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

If I am entitled to benefits under the Medicare, the Medicaid, or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me), in consideration for services provided to me by Futch Podiatry, I assign, transfer and convey the benefits payable under such program, policy or plan for services rendered to me. I authorize payment of benefits directly to Futch Podiatry, with such benefits to be applied to my bill. **I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts, deductibles, Durable Medical Equipment and any charges for services deemed to be non-covered, not pre-certified, or not pre-authorized by my insurance plan.**

_____ (*initial*) I give my consent for examination and treatment by Futch Podiatry.
_____ (*initial*) I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understand this form.
_____ (*initial*) I acknowledge that I have received and read the Financial Policy of Futch Podiatry.

To the best of my knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and the staff of any changes in my medical status.

Responsible Party Signature: _____

If not signed by the patient, please indicate relationship to the patient (i.e., Spouse, etc.)

Relationship: _____ Date: _____

Witness: (Office Use Only)_____ Date: _____