FAMILY FOOT CENTER

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2016 Updated Information Date: _____ Patient Number:_____

PATIENT INFORMATION:

Patient Name: Dr./Mr./Mrs./Ms. _____
Last First Middle

SSN: _____-____-___Race:_____Marital Status_____ Date of Birth: ____/____/___Age: _____

Address: _____
City State Zip

Home#(___)____- _____ Cell#(___)_____-_____ Work (___)_____-_____

Emergency Contact: Name _____Phone:_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION? IF YES _____ PROVIDE NAME AND TELEPHONE NUMBER

_____

_____

What is your current problem? _____

How long have you had this problem? _____***Any treatment?*** _____

Are you currently receiving home health care? _____

Have you had any surgeries since your last visit with us?____ If so what kind?

_____

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Are you currently taking a blood thinner?_____If so what amount?_____

ALLERGIES?

Penicillin	Yes ⁷ No ⁷	Anesthetics	Yes ⁷ No ⁷	Ibuprofen	Yes ⁷ No ⁷	Other_____
Sulfa	Yes ⁷ No ⁷	Tapes	Yes ⁷ No ⁷	Codeine	Yes ⁷ No ⁷	
Aspirin	Yes ⁷ No ⁷	Cortisone	Yes ⁷ No ⁷	Lidocane	Yes ⁷ No ⁷	

Current Height: _____ Current Weight: _____ B/P: _____ Temp. _____

MEDICATIONS & DOSE:_____

_____

_____

_PQRS(Physician Quality Reporting System) Questions:

Have you ever experienced 2 falls OR any falls with injury in the last year? ☐ Yes ☐ No

Have you received an influenza vaccination this year? ☐ Yes ☐ No

Have you received a pneumonia vaccination this year? ☐ Yes ☐ No

Do you drink caffeinated beverages: (sodas, coffee, tea): ☐ Yes ☐ No

If yes, how many per day: _____

Do you drink alcoholic beverages: ☐ Yes ☐ No If yes, how may per day: _____

Do you smoke: ☐ No ☐ <5 cigarettes per day ☐ ½ pack per day ☐ 1 pack per day ☐ >1 pack per day Length of use: _____ Quit Date: _____

Who do you live with: ☐ Spouse ☐ Alone ☐ Children ☐ Significant other ☐ Parents

Employment Status: ☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired

Occupation (current or former): _____

How may children do you have: _____

Family Physician: Dr._____ Address:_____

Phone Number (___)____-_____ Date of last visit with doctor: _____

Pharmacy Name and City: _____

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to the named provider(s) of professional services rendered. I authorize release of any medical information necessary to process this claim. I verify that the above information and medical history is correct to the best of my knowledge. I give my permission to the named provider(s)at Family Foot Center to perform and administer any necessary procedures

_____

PATIENT/GUARDIAN SIGNATURE **DATE**

_____

Staff Initial **Date**