Save Your Sole Foot & Ankle Specialists

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Personal Information

Name: ______________________________ Birth date: ____________ Today's date: ________________
Billing Address: ____Apt #__________________
City: ____ State: __________ Zip: ________________
Home phone: ___________________________ Cellular phone: ________________________________
Email address: ____
Ethnicity: African American / Asian American / Caucasian / Hispanic / Native American /
Pacific Islander (Hawaiian) / Other: ____
Preferred spoken language: ____
Age: ______ SS# last 4 digits: __________ Sex: M / F Occupation: ___________________________
Employer: ___________________________________ Work phone: ____________________________
Preferred pharmacy: __________________________ Location: ________________________________
Primary family physician: ____
How did you hear of our clinic? ____
Marriage status (circle): Single Married Widowed Divorced Other
Emergency contact (list parent if minor):Name ____
Relationship: ________________________________ Phone number: ___________________________

Today, my foot/ankle complaint is: 1. ____
(if time allows) 2. ____
The condition(s) has existed for (how long)?____
Is this related to a specific injury? _______________________ Date of injury? ___________________
Have you had this problem before? __________ How long ago? _______________________________
Previous treatment(s)?____
Allergic to latex? ___Yes ___No What reactions do you get if "yes"?______________________
Height:___________ **Weight**:___________ **Shoe Size**:__________ **Wears custom orthotics?**__________

Review of Systems: (check all that applies)
____In general good health ____Recent significant weight gain ____Recent significant weight loss
Eyes: ____ Does not apply ____Wear glasses/contact lenses ____Cataracts____Glaucoma ____Macular degeneration
Ears/Nose/Mouth/Throat: ____Does not apply ____Sinusitis ____Swollen lymph nodes
____Difficulty hearing ____Using hearing aids ___________________________Others (please describe)
Cardiovascular: ____Does not apply ____History of heart attack ____DVT ____High blood pressure
____History of stroke ____Heart murmurs ____High Cholesterol ______________Others (please describe)
Gastrointestinal: ____Does not apply ____History of stomach ulcer ____IBS ____Heartburn/reflux
____ Hiatal hernia ____ Hepatitis (A/B/C) ____Cirrhosis ______________________Others (please describe)
Genitourinary: ____Does not apply ____Kidney stones ____Benign prostate hypertrophy (in men)

Please turn over →

____Overactive bladder ____Frequent UTI ______________________________Others (please describe)
Pulmonary: ____Does not apply ____COPD ____Emphysema ____Asthma ____History of pulmonary embolism
Musculoskeletal: ____Does not apply ____Rheumatoid arthritis ____Psoriatic arthritis ____Osteoporosis
____Osteopenia ____Lower back pain/arthritis/herniated disc/pinch nerve ____Sciatica
____ History of chronic ankle sprains ____Osteoarthritis(where? __________________)
____Ehlers-Danlos syndrome _____________________Others (describe)
Skin: ____ Does not apply ____Eczema ____History of Athlete's foot _______________Others (describe)
Neurological:____Does not apply ____Migraine headache ____Numbness of hands ____Seizures
____Numbness of feet ____Multiple sclerosis ____Charcot-Marie-Tooth disease
Psychiatric:____Does not apply ____Depression ____Anxiety ____Bipolar disorder ____ADHD
____Others (describe)
Endocrine:____Does not apply ____Gout ____Type 1 Diabetes ____Type 2 Diabetes ____Thyroid problems
__________________________________Others(describe)
Hematologic:____Does not apply ____Bleeding disorder ____ Anemia _________________Others(describe)
Allergic/Immunologic:____Does not apply ____ Auto-immune disease ____HIV positive

What operations or surgeries have you had? ____
____

___**Yes** ___**No** Do you smoke tobacco? If **yes**, how much? ____________ Smoking how long? __________
If **no**, did you smoke in the past? ______________________ When did you quit? ___________________
___**Yes** ___**No** Do you use recreational drugs? If **yes**, how much? ____________ Using how long? _______
If **no**, did you use in the past? ________________________ When did you quit? ___________________
___**Yes** ___**No** Do you drink alcohol? How much do you drink? ___________________________________
___**Yes** ___**No** Do you exercise on a regular basis? If yes, please describe. _________________________
Does anything significant run in your family? (i.e. heart disease, diabetes, foot deformities) Please list all conditions. ____
____

If there's anything else in your medical history that may be important for your physician to know in order to facilitate your treatment? Please describe: ____
____

RELEASE OF MEDICAL INFORMATION

I authorize Save Your Sole Foot and Ankle Specialists to release and obtain medical information as required for my treatment and processing of my insurance claim. I realize that it is my responsibility to pay for any services rendered. A monthly billing charge will be added to all accounts over sixty days. I understand if any balance is unpaid after 60 days, it will be sent to collections. I will also be responsible for the cost of collections, plus attorney and court fees, which may amount to 50% of the original owed amount.

I request that payment of authorized insurance or Medicare benefits be made on my behalf to Save Your Sole Foot and Ankle Specialists for the services rendered to me.

I authorize Save Your Sole Foot and Ankle Specialists to release any information needed to determine these benefits or the benefits payable for related services.

I authorize release of medical information to my primary care physician or other specialty physicians related to my treatment.

Signature:___________________________________ Date:__________________________________