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: ______________________
(person financially responsible for patient)

Home #: (______)_______________Cell #: (______)_______________Work #: (______)________________
Address: ____
STREET CITY STATE ZIP

Birth Date: ______/______/______ SSN: ______-______-______ Employer: __________________________

Do you have a Living Will? Yes No

Do you have a Medical or Financial Power of Attorney? Yes No
If yes, whom: Name: ____ Phone #: (_____)________________

Emergency Contact: ___________________________________ 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)

____

Chief Complaint: ____

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: ________________________________