

**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: _____

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 #: (____) _____

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

Policy Holder: Self Responsible Party (as above)
 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? 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: _____