James B. Robison, D.P.M.

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PATIENT INFORMATION (please print)

Mr. Mrs. Ms. Dr.______________________________ **Birth date**______________

By what name would you like to be known?______________ **Social Security #**______________

Address______________________________ **City**__________ **Zip**__________

Phone: Work #______________ **Home**______________ **Cell**______________

Preferred Pharmacy (Name, City and Phone if known)______________________________

Employer______________________________ **Occupation**______________

Referred by:______________________ **Regular Physician**______________

Describe why you are here today______________________________

____

Emergency Contact Name______________ **Phone**__________ **City/State**__________

INSURANCE INFORMATION

Complete if insured is not the patient:

Name of Insured______________________________ **Relationship**______________

Insured Date of Birth______________ **Insured Social Security #**______________

Insured Complete Address______________________________

Note: If you require a **referral** or **authorization** for your office visits from your primary care physician and/or insurance company, it is your responsibility to obtain such and present it to the receptionist when you arrive.

ASSIGNMENT OF BENEFITS • FINANCIAL AGREEMENTS

I hereby give lifetime authorization for payment of insurance benefits to be made directly to James B. Robison, D.P.M. and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In event of default, I agree to pay all costs of collection and reasonably necessary attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

CANCELLATION POLICY: To ensure equal Patient access and office efficiency, absence or cancellations within 24 hours of a scheduled appointment will incur a $25 fee.

Signature ______________________________ **Date** ______________

Patient Name: ______________________________ **Date:** ______________

Referring Physician Name and Address: ____

History & Medical Information

1. **Explain your foot/ankle problem** ☐ Right ☐ Left ____

____

2. **When did pain/discomfort begin (date):** ____
   Describe pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other ______________________

3. **What makes the pain/discomfort better:** ____

4. **Have you had a physical trauma?** ☐ No ☐ Yes ____

5. **Have you had an accident?** ☐ No ☐ Yes ____

6. **Occupation:** ______________________________ **Is your problem work related?** ☐ Yes ☐ No

7. **Past Medical History:**
   ☐ Anemia
   ☐ Bleeding Disorders
   ☐ Cancer ____________
   ☐ Diabetes
   ☐ Epilepsy
   ☐ Gout
   ☐ Heart failure
   ☐ Hepatitis
   ☐ High Cholesterol
   ☐ HIV / AIDS
   ☐ High Blood Pressure
   ☐ Kidney Disease
   ☐ Lung/Respiratory Disorders
   ☐ Mitral Valve Prolapse
   ☐ Nerve Disorders
   ☐ Neurological Disorders
   ☐ Prostate Disorders
   ☐ Osteoarthritis
   ☐ Other Arthritis
   ☐ Rheumatic Fever
   ☐ Stroke
   ☐ Thyroid Disorders
   ☐ Other: ____________

8. **List all medications/herbs/vitamins:** ☐ **NONE** ______________________________________

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9. **Allergies:** (Describe reaction) ☐ **NONE**
   ☐ Penicillin ________________
   ☐ Anesthesia ________________
   ☐ Nickel / Metal ______________
   ☐ Aspirin ________________
   ☐ Shellfish ________________
   ☐ Radiographic Contrast Dye ______________________________
   ☐ Narcotic Agent / Codeine ______________
   ☐ Sulfa Drugs ______________________
   ☐ Other ____

10. **Are you currently pregnant?** ☐ No ☐ Yes ____

11. **Surgical History:** Have you had surgery? ☐ Yes—if yes, describe below ☐ No
    Surgery / Date: ____

    ____

12. **Social History:** (Only check what is pertinent to you)
    ☐ Tobacco Use ☐ Alcohol Use ☐ Exercise habits______________________________
    ☐ Caffeine Use ☐ Drug use (recreational, IV)

13. **Family History: (List relationship of family member(s) who have had these problems):**
    ☐ Diabetes________________
    ☐ Hypertension ______________
    ☐ Rheumatology ____________
    ☐ Heart Disease ______________
    ☐ Stroke ____________________
    ☐ Bleeding Disorders __________
    ☐ Kidney Disease ______________
    ☐ Mental Illness ______________
    ☐ Cancer ____________________
    ☐ Other family History: ____

14. **Height:** __________ **Weight:** __________ **Shoe size:** ______________