Marin Foot and Ankle

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www.marinfootandankle.com

PATIENT INFORMATION (please print)

Mr. Mrs. Ms. Dr. _____

By what name would you like to be known? _____ **Birth date** _____

Address _____ **City** _____ **Zip** _____

Phone (check best number) ❑**Home** _____ ❑**Cell** _____

Email Address: _____

Preferred Pharmacy (Name & City) _____

Employer _____ **Occupation** _____

Referred by: _____ **Regular Physician** _____

Describe why you are here today _____

_____

Emergency Contact Name _____ **Phone** _____

INSURANCE INFORMATION - Complete if insured is not the patient:

Name of Insured _____

Insured Date of Birth _____ **Relationship** _____

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 Marin Foot and Ankle and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges if they are not 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: _____ **DAT:** _____

HISTORY & MEDICAL INFORMATION

1. Explain your foot/ankle problem? ☐ Right ☐ Left _____

2. When did your issue (pain/discomfort) begin (date) _____

   Describe the discomfort/pain ☐ Burning ☐ Numbness ☐ Sharp ☐ Other _____

3. What makes the pain better? _____

4. Have you had a physical trauma (describe)? _____

5. Have you had an accident (describe)? _____

6. Is problem work related? ☐ Yes ☐ No Female Patients: Are you pregnant? ❒ No ❒ Yes

7. Previous foot or ankle surgeries (include date and type) _____

_____

8. FAMILY HISTORY (siblings, parents, grandparents) Please check those that apply

❑ Arthritis	❑ Heart Disease	❑ Kidney Disease
❑ Cancer	❑ High Blood Pressure	❑ Mental Illness
❑ Diabetes	❑ Stroke	❑ Bleeding Problems

9. PAST/CURRENT MEDICAL HISTORY Please check those that apply

❑ Anemia	❑ Gout	❑ Hepatitis	❑ Mitral Valve Prolapse
❑ Asthma	❑ Other Arthritis	❑ High Blood Pressure	❑ Nerve Disorder
❑ Bleeding Disorders	❑ Rheumatic Fever	❑ High Cholesterol	❑ Neurological Disorder
❑ Cancer	❑ Stroke	❑ HIV/AIDS	❑ Osteoarthritis
❑ Diabetes	❑ Thyroid Disorder	❑ Kidney Disease	❑ Prostate Disorder
❑ Epilepsy	❑ Heart Failure	❑ Lung/Respiratory Disorder	❑ Other _____

10. ALLERGIES (describe reaction such as rash etc) ❑ None

❑ Aspirin	❑Narcotic/Codeine	❑Penicillin	❑Sulfa drugs
❑Gen. Anesthesia	❑Nickel/Metal	❑Radiographic contrast dye	❑Other
❑Latex	❑Novacaine	❑Shellfish	

11. SOCIAL HISTORY

Do you smoke? ❒ No ❒ Yes ❒ Former

Exercise Habits (type, frequency) _____

_____

List medications, herbs and supplements you take: ❑ None _____

_____

Weight _____ Height _____ Shoe Size _____