Sterling Foot Care

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NAME: _____ BIRTHDATE: _____

ADDRESS: _____ CITY: _____

ZIPCODE: _____ STATE: _____ SS# _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ EMAIL ADDRESS: _____

AGE: _____ SEX: _____ MARITAL STATUS: _____

What is your preferred method of contact? (Circle one) HOME PHONE OR CELL

How did you hear about our office? _____

What is your primary language you speak? _____

What Race are you? (***New Requirement of the Federal Government***)

○ White ○ Asian ○ Black or African American ○ Native Hawaiian/Other Pacific Islander

○ American Indian or Alaska Native ○ Hispanic or Latino ○ Other

General Health Information

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

What problem are we seeing you for today? _____

Please list all known allergies or sensitivities: _____

Please list all medication you take regularly: _____

Primary Care Physician

Family Physician _____ Physician Phone Number _____

Last Visit _____

Medical History

Any past foot/ankle problems
- ○ Yes — What? _____
- ○ No

Any past foot/ankle surgeries
- ○ Yes — What? _____
- ○ No

Do you have any artificial joints?

- ○ Knee _____
- ○ Hips _____

Other_____

Are you Pregnant Or Breastfeeding?
- ○ Yes
- ○ No

History of Diabetes?

Do you have Diabetes? (Circle one) Yes or No Controlled By? (Circle one) Insulin or Pills

If Yes: How Long? _____ Last Blood Sugar? _____

Please check any/all of the following that apply to you:

☐ Arthritis	☐ Kidney Trouble	☐ HIV/AIDS
☐ Lungs	☐ Cancer	☐ Asthma
☐ Ulcers	☐ Gastric Problems	☐ Anemia
☐ High Blood Pressure	☐ Gout	☐ Tuberculosis
☐ Rheumatic Fever	☐ Liver Disorders	☐ Stroke
☐ Heart Trouble	☐ Multiple Sclerosis	☐ Epilepsy
☐ Lupus	☐ Hepatitis	☐ Peripheral Vascular
☐ Other_____	☐ Parkinson Disease	☐ Neuropathy
☐ Blood Clot	☐ Hearing Trouble	☐ Neurological Disorder
☐ Skin Disorder	☐ Thyroid Disorder	☐ Cerebral Palsy
☐ Fibromyalgia	☐ Glaucoma	☐ High Cholesterol

Family History

Is your father living?

- ○ Yes
- ○ No

Cause of Death (Circle one)
Natural Causes Cancer Diabetes
Heart Attack Stroke Other_____

Is your mother living?

- ○ Yes
- ○ No

Cause of Death (Circle one)
Natural Causes Cancer Diabetes
Heart Attack Stroke Other_____

Family has history of please check any/all of the following that apply:

□ Heart Disease □ Bleeding Disorder □ Neurological Disorder

□ Stroke □ Diabetes □ Hammertoes/Bunions

□ Flatfeet □ Circulation Problems

Patient Social History

Patient Smoking Status:

□ Current Smoker □ Never Smoker
□ Former Smoker **Date Quit Smoking: _____**

Smoking Quantity is:

- ○ ½ Pack per day
- ○ 1 Pack per day
- ○ 2 or more per day

Alcohol Quantity is:

- ○ None
- ○ 1-2 per week
- ○ 1-2 per day
- ○ 2 or more per day

Employer _____

Employment Type:

- ○ Sit at job
- ○ Stands at job How many hours? _____
- ○ Stands and walks at job?
- ○ Sits and stands at job
- ○ Retired/Unemployed
- ○ Student

INSURANCE INFORMATION

If you gave us your Insurance card(s) and your Insurance is in your name you do not need to fill out this section.

PRIMARY INSURANCE _____

POLICY HOLDER NAME: _____ DOB: _____

SECONDARY INSURANCE _____

POLICY HOLDER NAME: _____ DOB: _____

HIPAA INSURANCE INFORMATION

I do hereby grant permission to Dr. Brown and Beneson, DPM to administer medication and perform procedures as may be deemed necessary in the interest and care of myself. I understand I am responsible for paying any or all balance (s) due for services rendered. I authorize the office to furnish my insurance company (s) with all necessary information regarding my present illness or injury. I also authorize any necessary test, laboratory tests, x-rays, and or HIV/AIDS tests to be performed if the doctor deems necessary. I understand that the office strives to achieve the highest standards of ethics and integrity in performing services and complies with the government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule".

PATIENT/GUARDIAN

SIGNATURE: _____

DATE: _____