Preferred name _____

Last Name _____ **First Name** _____ **MI** _____

Primary Language _____ **Ethnicity** _____ **Race** _____

Social Security #_____-_____-_____ **Date of Birth** _____ **Age** _____ **Gender M / F**

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

Billing Address (same) _____

Home Phone (_____**)** _____ **Cell Phone (**_____**)** _____ **Email** _____

Employer _____ **Occupation** _____

Work Phone (_____**)** _____

Name of person responsible for bill _____ **SS#**_____-_____-_____ **Date of birth** _____

Spouse/parent's name _____ **SS#**_____-_____-_____ **Date of birth** _____

Emergency _____ **Relationship** _____ **Phone (**_____**)** _____

INSURANCE INFORMATION

Primary Insurance _____ **Secondary Insurance** _____

ID # _____ **Copay** _____ **ID #** _____ **Copay** _____

Group #_____ **Eff. Date** _____ **Group #**_____ **Eff. Date** _____

Policy Holder Name _____ **Policy Holder Name** _____

Relation to Patient _____ **Relation to Patient** _____

DOB ____/____/_____ **Employer** _____ **DOB** ____/____/_____ **Employer** _____

Financial/Treatment Agreement: Under all circumstances, I agree to financial responsibility of my account. I authorize the doctors of Foot &Ankle Center to examine, to photograph, to administer treatment, and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle condition.

☐ **I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.**

☐ **I refuse to accept a copy of the Notice of Privacy Practices.**

_____ _____

Patient Signature (18 yrs or over) **Date**

_____ _____ _____

Parent/Guardian Name & Relation (Please Print) **Parent or Guardian Signature** **Date**

Medicare Lifetime Authorization

Provider's Name: **Foot & Ankle Center of Wenatchee** Patient's Name: **above**

Provider's Address: **616 N. Chelan, Wenatchee, WA 98801** HIC: _____

Authorization Period: **From: Current To: D/C from office** Patient's Address: **above**

I request that payment under the medical insurance program be made either to me or to the provider named above on any bills for services furnished to me during the effective period of this authorization. I also authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

Date: _____ **Patient's signature:** _____

Describe your foot problem:_____

How long has it been bothering you? _____ How bad is the pain? (Scale from 0 - 10) _____

How would you describe the pain? _____ (achy, dull, sharp, burning, shooting, throbbing, knifelike etc)

Has your problem been getting worse, unchanged or better? or other _____

Is there any limitation in activities due to this problem? (i.e. recreation/daily activities) _____

What treatments (if any) have you received/tried for this condition prior to your visit with us? _____

_____

Any past problems with your feet or ankles? _____

Please check all boxes that apply to you. Write in any missing information

Past Medical History ☐ **None**

- ☐ AIDS/HIV
- ☐ ADD/ADHD
- ☐ Alcoholism/Drug Dependency
- ☐ Allergies
- ☐ Alzheimers/Dementia
- ☐ Anemia
- ☐ Artificial Joints - Location: _____
- ☐ Arthritis-Location: _____
- ☐ Back Injury
- ☐ Blood Clots
- ☐ Cancer – Type:_____
- ☐ Depression/Anxiety
- ☐ Diabetes – Type 1 or Type 2
  Current A1c Level _____
- ☐ Difficulty Healing
- ☐ Epilepsy
- ☐ Gout
- ☐ Head Trauma
- ☐ Heart Disease/Failure
- ☐ Heart Valve Implant/Defibulator
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hormone Deficiency
- ☐ Kidney Disorder
- ☐ Liver Disease/Hepatitis A, B, C
- ☐ Lung Problems/Asthma
- ☐ Neurological Disorder
- ☐ Organ Transplant
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea – CPAP (yes / no)
- ☐ Skin Condition:_____
- ☐ Stomach/Intestinal Problems (Acid Reflux, Heartburn, GERD)
- ☐ Stroke
- ☐ Thyroid Disease (Goiter, low, high)
- ☐ Other:

Family History ☐ **None** **D – Dad, M - Mom**

- D / M Alcoholism/drug dependency
- D / M Arthritis
- D / M Bleeding disorders
- D / M Bunions
- D / M Cancer
- D / M Circulation problem to legs
- D / M Congenital foot deformity
- D / M Diabetes
- D / M Flat foot
- D / M Hammertoes
- D / M Heart Disease
- D / M High Cholesterol
- D / M Nerve or muscle disorder
- D / M Stroke

Review of Symptoms ☐ **None**

- ☐ Headache
- ☐ Recent Weight Loss
- ☐ Weakness/fatigue
- ☐ Recent Vision Changes
- ☐ Change in skin and nails
- ☐ Rashes/Itching
- ☐ Joint pain/Stiffness
- ☐ Leg cramps/muscle pain
- ☐ Numbness/tingling in feet
- ☐ Pregnant
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Decreased circulation to legs
- ☐ Excessive thirst/hunger
- ☐ Shortness of breath
- ☐ Nausea/vomiting
- ☐ Chest pain
- ☐ Heart murmur
- ☐ Depression
- ☐ Other: _____

Allergies (Drugs, Metal, Latex etc)-include reaction _____

Medications (dosage & frequency) _____

_____

Surgical History (type & yr) _____

_____

Tobacco use YES NO (_____packs/day x _____yrs) **Former Tobacco User YES NO** **Alcohol Use YES NO**

Height _____ft _____in **Weight** _____ **Shoe Size**_____

Referring Doctor's Name:_____ **Primary Doctor's Name:**_____

Preferred Pharmacy (name and phone #) _____