GREEN FOOT & ANKLE CARE, LLC
PATIENT UPDATE

Please Use Blue or Black Ink

Patient Legal Name: _____ Nickname: _____
FIRST MIDDLE INITIAL LAST

Primary Phone: (____) _____ Secondary 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 Phone: (___) _____ Cell Phone (___) _____ Work Phone (___) _____
Address: _____
STREET CITY STATE ZIP

Birth Date: _____/_____/_____ SSN: _____-_____-_____ Employer: _____

**** If you have a Medical or Financial Power of Attorney, all paperwork must be presented to the office at the time of the appointment. Failure to provide legal documentation may result in the cancellation of the appointment.**

Emergency Contact not living with you: _____ Relationship: _____
Home Phone: (___) _____ Cell Phone (___) _____ Work Phone (___) _____

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

Primary Insurance: _____
ID #: _____
Group #: _____
Subscriber Name: _____
Subscriber DOB: _____
Subscriber SSN: _____
Subscriber Employer: _____
Subscriber Address: _____
Relationship to Patient: _____

Policy Holder: ☐ Self ☐ Responsible Party (as above)
☐ Other: Complete the following

Secondary Insurance: _____
ID #: _____
Group #: _____
Subscriber Name: _____
Subscriber DOB: _____
Subscriber SSN: _____
Subscriber Employer: _____
Subscriber Address: _____
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	Chemical Dependency	High Blood Pressure	Shortness of Breath
Anemia	Circulatory Problems	History of Chemotherapy	Stroke
Angina	Diabetes	Kidney Problems	Swelling in Ankle/Foot
Arthritis	Epilepsy/Seizures	Liver Disease	Thyroid Disease
Artificial Heart Valves/Joints	Fainting	Mitral Valve Prolapse	Transfusions of Blood
Asthma	G.E.R.D.	Phlebitis	Tuberculosis
Back Problems	GI Ulcers/Bleeding	Pneumonia	Ulcers
Bleeding Disorder	Gout	Psychiatric Care	Varicose Veins
Blood Clots/DVT	Heartburn/Reflux	Respiratory Disease	Weight Loss
Blood Thinners	Hemophilia	Rheumatic Fever	
Cancer	Hepatitis or Jaundice	Sexually Transmitted Disease	

Any other medical conditions not listed here _____

Surgical History, please list all surgeries _____

_____

Hospitalizations, other than for surgeries _____

_____

Any Major Injuries_____

Allergies - Include allergies to medications, food, etc.

_____

Current Medications - Include both prescription and over the counter medications (Attach list if needed)

_____

_____

Do you take contraceptives? Yes ___ No ___

Family Doctor: _____

Phone: _____ Date Last Seen: _____

Cardiologist: _____

Phone: _____ Date Last Seen: _____

Endocrinologist: _____

Phone: _____ Date Last Seen: _____

Infectious Disease Doctor: _____ Phone: _____

Neurologist: _____ Phone: _____

Rheumatologist: _____ Phone: _____

Vascular Surgeon: _____ Phone: _____

Preferred Pharmacy: _____ Address: _____ Phone _____

DISCLOSURE AUTHORIZATION

May we leave a message at your home or with other residents? Yes No

May we leave a message on your answering machine/voicemail? Yes No

Whom may we discuss your medical/financial information with?

Name _____ Relationship _____

Home _____ Work _____ Cell _____