CONNELL FOOT CARE

Welcome to Connell Foot Care. Please take a few moments to fill out the information below to complete your medical records. If you have any questions, please feel free to ask for assistance.

Patient Information:

Last Name:_____ _____First Name:_____Middle Initial:_____

SS#:_____DOB:_____Gender: Male/Female (circle one)

Full Time AZ Resident: Yes/No (circle one) AZ Address:_____

City:_____Zip Code:_____ Home Phone:_____Cell Phone:_____

Employer:_____Work Phone:_____

Spouse/Guardian:_____Phone:_____

Pharmacy Name:_____Phone:_____Cross Streets:_____

Out of State Address:_____State:_____Zip Code:_____

Phone:_____**Email Address:_____**

Insurance Name:_____Policy Holder Name:_____

DOB:_____SS#:_____

Family Doctor:_____Phone:_____

City:_____State:_____

Were you Referred by your Family Doctor? yes/no

Were you Referred by one of our patients? yes/no

If no, how did you find us?_____

Does your insurance require a referral? yes/no Do you have a referral? yes/no

Authorization to Release Information and Assignment Of Benefits:

I Authorize payments of medical benefits to Connell Foot Care or it's providers for services rendered or to be rendered in the future without obtaining my signature on each claim submitted and the signature below will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary for treatment. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES. If this should need to be referred to a collection agency, I will be responsible for any collection and or legal fees incurred. My signature below indicates that I have read and also understand this office policy and procedure.

Responsible Party:_____Date:_____

New Patient History: Patient Name:_____Date:_____

Height:_____Weight:_____

Circle conditions below for which you have been treated:

Anemia Arthritis Asthma Bleeding Problems Cancer Diabetes Epilepsy Fibromyalgia

Heart Trouble Hepatitis MRSA High Blood Pressure Infectious Disease Kidney Disease

Liver Disease Stomach Ulcer Poor Circulation Raynauds DVT RSD Legally Blind

None Of The Above:_____ Other Conditions not listed:_____

_____

Please List Your Current Medications or Provide A List of your Medications:

_____

Circle any of the following to which you are allergic. I have no known allergies._____

Penicillin Keflex Augmentin Aspirin Codeine Vicodin Percocet Sulfa Neosporin

Topical Iodine Celebrex Epinephrine Latex **Other:_____**

Major Surgeries:

Brain Neck Back Shoulder Elbow Hand Heart Liver Kidney Lung Stomach Gall Bladder

Eye Skin Leg Ankle Foot Toe Heal Cosmetic **Other:_____**

What condition(s) are you being seen for today?:

Bunion Heel Pain Ingrown Nail Nail Fungus Hammertoe Corns/Callouse/Nail Care Nerve Pain

Diabetic Foot Care Ulcer Infection Injury 2nd Opinion **Other:_____**

Which Foot is Affected? Left/Right/Both

How long has this been a problem? ____Days ____Weeks ____Months ____Years

History of Similar Problem? Yes/No

Prior Care for Same Problem? Yes/No By Who?_____

Have you ever had foot surgery? Yes/No By Who?_____

Do you wear Orthotics? yes/No

Do you do any of the following on a regular basis? Run Martial Arts Step Aerobics Hike Basketball

Football Baseball Racket Sports Bowling Golf Dancing Motocross Ballet

Does your job involve prolonged standing and/or walking? Yes/No

Patient Name: _____ Date:_____

Do you have any other health problems or concerns we need to know about? Yes/No

If YES please list them:_____

_____

Family History: Circle M (mother) F (father)

Diabetes M/F Heart Disease M/F Arthritis M/F Bunion M/F Cancer M/F High Blood Pressure M/F

Other Conditions: _____ M/F_____M/F

Father Living? Yes/No Mother Living? Yes/No

Social History:

Married/Single Do you live with: Spouse Significant Other Alone Assisted Living With Children

Retired? Yes/No Employed outside the home? Yes/No

Race: Caucasian Hispanic Native American Other:_____

Current Tobacco Use: Yes/No

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given the opportunity to review or provided with a copy of the Notice of Privacy Practices and that I have read or have had the opportunity to read them if I so choose. In sigining below I admit an understanding of the Privacy Practice as it applies to my health records and information.

Patient Name:_____ Date:_____

Parent/Guardian/Authorized Representative:_____

Signature:_____

I Authorize Medical Information to Be Disclosed to:

Name:_____ Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____