CHART#______________________________

Montgomery Foot Care Specialists

ALL AREAS MUST BE COMPLETED

Social Security#:_______________________________

Name: _______________________________________ Date of Birth: ____

Address: _____________________________________ Home Phone: ____

City ____ Cell Phone: ____

State, Zip Code__________________________________ Cell Carrier ____

Phone: ____ Would like to receive text notifications? Y ______ N _______

Email: ____ Marital Status: S_____ D_____ M_____ W_____

Patient Employment: ____________________________ Gender: M__________ F__________

Emergency Contact: ______________________________ Relationship: ____

Emergency Contact Phone Numbers: ____

Whom may we thank for referring you: ____

Insurance

Who is responsible for this account: _______________________________ Relationship to patient: __________________

Resp. Party DOB/SS#: ______________________________________ Phone Number: _______________________________

Primary Insurance: _____________________________ Secondary Insurance: ___________________________________

Policy/Contract Number: ___________________________ Policy/Contract Number: ___________________________________

Group Number: ___________________________________ Group Number: ____

Race: ________________ Language: ________________ Ethnicity: Hispanic or Non-Hispanic

Primary Care Physician: ________________________ Last Seen: ____

Endocrinologist: ________________________________ Last Seen: ____

Dermatologist: _________________________________ Heart/Vascular Doctor: _________________________________

***Preferred Pharmacy:** ___________________________ **Phone Number**: ___________________________

Allergies

Please list ALL allergies

____
____
____

Surgical History

____
____
____
____

PERSONAL MEDICAL HISTORY

(CIRCLE ALL THAT APPLY)

Frequent Headache / Migraines	High Blood Pressure	Hemophilia	Ankle Pain
Kidney Disease	Arthritis	Hepatitis / Jaundice	Athlete's Pain
Fainting	Psychiatric Treatment	Liver Disease	Bunion
Tuberculosis	Asthma / Hay Fever / Shortness	Low Blood Pressure	Corn
Emphysema	Sexually Transmitted Disease	Radiation Treatment	Callus
Heart Trouble	AIDS / HIV	Rash	Foot and Leg Cramps
Stroke	Artificial Heart Valves or Joints	Swollen Neck Glands	Flat Feet
Neuropathy	Back Problem	Stomach Disorders / Ulcers	Heel Pain
DVT (Blood Clots)	Bleeding Disorders	Blood Thinners: _________	Ingrown Nails
Anemia / Blood Disorders	Cancer	Varicose Veins	Plantar Fasciitis
Drug / Alcohol Abuse	Chest Pain on Mild Exertion	Weight Loss, unexplained	Plantar Warts
Epilepsy / Seizures	Circulatory Problems	Thyroid / Parathyroid Disease	Tired Feet
Ear / Nose / Throat Problem	Dialysis M W F OR T TH SA	Swelling in feet / legs	Other: ___________________
Eye Trouble	Diabetes- HA1C: _________ avg. blood sugar: ________	Foot Ulcers	

What foot complaints do you have? (Include date and place of injury if applicable) ____________________________________

____

____

Has an immediate family member had any of the following (please indicate relationship) (i.e. mother, father, grandparents, siblings or children)

Cancer: _______________________________________ DVT (Blood Clots): ______________________________________

Diabetes: ______________________________________ Mental / Emotional Disorders: ____________________________

Heart Trouble: __________________________________ Arthritis: ____

High Blood Pressure: _____________________________

Are parents still living? Yes or No If not, cause of death? ____

Health Review

(Circle any symptoms you have had in the past 3 months)

General	Fever Chills Fatigue Weight loss Weight gain
Head	Headache Visual Problems Hearing Problems Light Sensitivity
Cardiovascular	Chest Pain Palpitations Dizziness Swelling of legs Other
Hematology	Anemia Abnormal bleeding/bruising Blood Clots Other blood disorders
Respiratory	Persistent Cough Wheezing Shortness of Breath
Gastrointestinal	Difficulty swallowing Indigestion/Heartburn Abdominal Pain Change in bowls
Urinary	Painful Urination Frequent nighttime urination Bladder leaking Other: ___________
Musculoskeletal	Joint pain/swelling/stiffness Back Pain Arthritis Muscle Weakness
Skin	Skin Rash Suspicious Lesions Itching
Neurological	Numbness of hands/feet Seizures Tremors Paralysis
Psychiatric	Depression Anxiety Problems Sleeping Memory loss
Endocrine	Heat/Cold Intolerance Hot Flashes Change in hair/skin textures Excessive thirst

Authorization

I have reviewed the information on the questionnaire and it is accurate to the best of my knowledge I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any changes in my medical condition, I will inform the doctor.

I authorize my insurance company to pay the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize use of this signature on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: ____ Date: ___________________________

Print: ____

.

Staff Initial:_____________________