Morris Podiatry Associates

Name: _____
First Middle Initial Last

Birthday: _____ Sex: ❑ Male ❑ Female

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American
❑ White (Caucasian) ❑ Native Hawaiian or Pacific Islander ❑ Other ❑ I Decline to Answer

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I Decline to Answer

SSN: _____

Address: _____

Employment Status: ❑ Employed ❑ Unemployed ❑ Full-Time Student ❑ Part-Time Student ❑ Other ❑ Retired
❑ Child

Preferred Phone Number: _____

Email Address: _____

In Case of Emergency Contact: _____ Phone: _____

Whom may we thank for referring you: _____

Primary Care Physician: _____ Date of Last Visit: _____

Patient Pharmacy: _____

Are you allergic to any medication? ❑ Yes ❑ No If yes, which medications? _____

Please List Any Medications that you are Currently Taking: _____

Have you received an influenza immunization (Flu Shot) this year? ❑ Yes ❑ No Date: _____

Have you ever received a Pneumonia vaccination? ❑ Yes ❑ No Date: _____

Do you use tobacco products? ❑ Currently Every Day ❑ Occasionally ❑ Former ❑ Never

Have you ever been diagnosed with Diabetes? ❑ Yes ❑ No If yes, result of last A1C test? _____

Have you ever been diagnosed with Hypertension (High Blood Pressure)? ❑ Yes ❑ No

Height: _____ Weight: _____ Shoe Size: _____

Have you ever broken a bone in your foot or ankle? ❑ Yes ❑ No

Have you had any previous foot or ankle surgery? ❑ Yes ❑ No

Please describe your foot/ankle problem? _____

How long has the problem been present? _____

Have you had any treatment or taken anything for it? _____

Are you experiencing any of the following?

Varicose Veins ..... ❑ Yes ❑ No	Extremity(s) Cool ..... ❑ Yes ❑ No	Hair Loss on Legs ..... ❑ Yes ❑ No
High Blood Pressure ..... ❑ Yes ❑ No	Cramps in legs/feet ..... ❑ Yes ❑ No	Leg or Foot Ulcers ..... ❑ Yes ❑ No
Arthritis ..... ❑ Yes ❑ No	Joint Pain ..... ❑ Yes ❑ No	Gout ..... ❑ Yes ❑ No
Lower Back Pain ..... ❑ Yes ❑ No	Knee Pain ..... ❑ Yes ❑ No	Back Problems ..... ❑ Yes ❑ No
Joint Stiffness ..... ❑ Yes ❑ No	Muscle Cramps ..... ❑ Yes ❑ No	Paralysis ..... ❑ Yes ❑ No
Restricted Motion ..... ❑ Yes ❑ No	Weakness ..... ❑ Yes ❑ No	Ankle Sprain ..... ❑ Yes ❑ No
Arch Pain ..... ❑ Yes ❑ No	Broken Ankle ..... ❑ Yes ❑ No	Broken Foot Bone ..... ❑ Yes ❑ No
Bunions ..... ❑ Yes ❑ No	Calluses ..... ❑ Yes ❑ No	Childhood Foot Problems ..... ❑ Yes ❑ No
Corns ..... ❑ Yes ❑ No	Flat Feet ..... ❑ Yes ❑ No	Gait (Walking) Problems ..... ❑ Yes ❑ No
Hammer/Mallet Toes ..... ❑ Yes ❑ No	Heel Pain ..... ❑ Yes ❑ No	High Arch Feet ..... ❑ Yes ❑ No
Muscle Stiffness ..... ❑ Yes ❑ No	Neuroma ..... ❑ Yes ❑ No	Orthotic Use ..... ❑ Yes ❑ No
Shoe Insert Use ..... ❑ Yes ❑ No	Itching ..... ❑ Yes ❑ No	Warts ..... ❑ Yes ❑ No
Dryness ..... ❑ Yes ❑ No	Hives ..... ❑ Yes ❑ No	Athlete's Foot ..... ❑ Yes ❑ No
Fungal Nails ..... ❑ Yes ❑ No	Ingrown Nails ..... ❑ Yes ❑ No	Rash ..... ❑ Yes ❑ No

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES...

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 UNDERSTAND THE NOTICE.

_____ _____.

PATIENT'S NAME (please print). **Date.**

_____

PARENT OR AUTHORIZED REPRESENTATIVE (If applicable).

_____

SIGNATURE OF PATIENT, PARENT OR AUTHORIZED REPRESENTATIVE

IN CASE OF EMERGENCY OR RELEASE OF INFORMATION PLEASE PROVIDE INFORMATION ON NEXT OF KIN, RELATIVE OR GUARDIAN.

_____

NAME (relationship)

_____

ADDRESS

_____

PHONE

_____

DATE OF BIRTH

Authorization

I have reviewed the information on this 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 change in my medical status, I will inform the doctor.

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the 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 _____

Payment is due in full at time of treatment unless prior arrangements have been approved.