FAMILY FOOT & ANKLE CENTER, INC.

WELCOME TO OUR OFFICE: Complete the following information for your case history file. (Please Print)

Patient's Name (Last) (First) (M.I)				Sex: □ Male □ Female	Marital Status: □ Single □ Married □ Divorced □ Widowed	Today's Date
Social Security Number	Date of Birth	Age	Home Phone Number	Email Address		
Home Address			City		State	Zip
Name of Employer			Occupation		Business Phone	
Spouses Name	Social Security Number		Date of Birth	Occupation		
Employer			Business Address		Business Phone	
Name of Contact in Case of Emergency			Address & Phone Number		Relationship	

Primary Medical Insurance Name of Insured	**Secondary Medical Insurance** Name of Insured
Family Physician Phone #	Are you currently under Physician's Care: ☐ No ☐ Yes For What? Date Last Seen_____
Who may we thank for referring you to our office?	**Family History** ☐ Diabetes ☐ Hypertension ☐ Bleeding Disorder ☐ Seizures ☐ Foot Problems

Social History Tobacco (ppd)_____Caffeine (cpd)_____Alcohol_____Illicit Drug Use_____	Sports/Activities?

Please describe your chief foot/ankle complaint?

Have you been treated for this before?	What was done?	Previous Doctor?

Past Medical History	**Past Surgeries/Hospitalizations** Date
□ Cancer □ Diabetes □ Hypertension □ Bleeding Disorder/Anemia □ Gastric Ulcers □ Gout Other_____	

Medications	**Allergies** **Reaction**

I hereby give **Dr. Cynthia Miller, Dr. Caron Harner, Dr. James Robinette, Dr. Kelly Heppert, Dr. Michael Doran permission** to administer treatment and perform such procedures as may be necessary for the diagnosis and treatment of my foot and/or ankle condition. Also, I authorize the release of any medical information necessary to process my claim. I also authorize payment to the above mentioned doctor from insurance company(ies) for services rendered to me. My permission is given to the above mentioned doctor to keep my other medical care providers informed of my medical information, progress and treatment obtained. I understand that as a courtesy, Family Foot and Ankle Center will file insurance claims for me and that I am ultimately responsible for payment of all services rendered.

Signature:	Date: