FAMILY FOOT AND ANKLE CENTER

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	
Social Security Number	Date of Birth	Age	Home or Cell Phone Number	Email Address	
Home Address			City	State	Zip
Name of Employer			Occupation	Business Phone	
Do you have a Living Will?		**Do you have a Power of Attorney?**		**POA Phone Number**	
Spouse/Resposible Party		Social Security Number		Date of Birth	
Name of Contact in Case of Emergency		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 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 ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Bleeding Disorder/Anemia ☐ Gastric Ulcers ☐ Gout ☐ Urinary Incontinence	**Past Surgeries/Hospitalizations** Date	

Medications	**Allergies** **Reaction**
	Pharmacy **Phone number or Zip code**

I hereby give **Dr. Cynthia D. Miller , Dr. Caron E. Harner, Dr. Kelly Heppert, Dr Michael Doran, Dr Matthew Hamilton, Dr. Veronica Marrochello** 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 all insurance claims for me and I am ultimately responsible for payment of all services rendered.

Signature:	Date: