Date _____

Foot Specialist Associates P.C.

Chart # _____

Identifying & Insurance Information

Identifying Information

Name _____ **DOB:** ___/____/____ **SS#:**_____

Sex: ☐ M ☐ F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Email: _____ **Spouse/Partner Name:**_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home #:_____-_____ **Cell #:**_____-_____ **Other #:**_____-_____

Employer:_____ **Phone:** _____

Employer Address:_____

City:_____ **State:**_____ **Zip:**_____

Insurance

Primary Insurance: _____ **Are you the insured?** ☐ Yes ☐ No

Insured Information

Subscriber Name:_____ Relationship to insured: ☐ Spouse ☐ Child ☐ Self ☐ Other

Phone #: _____-_____ Sex: ☐ Male ☐ Female DOB:_____ / _____ / ____

Address: _____

Policy ID: _____ Group ID: _____ Employer:_____

Secondary Insurance: _____ **Are you the insured?**

Insured Information

Subscriber Name:_____ Relationship to insured: ☐ Spouse ☐ Child ☐ Self ☐ Other

Phone #: _____-_____ Sex: ☐ Male ☐ Female DOB:_____ / _____ / ____

Address: _____

Policy ID: _____ Group ID: _____ Employer:_____

Feedback

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Friend ☐ Family Member ☐ Other: _____

What is the reason for your visit today? _____

_____ **Result of accident or work injury?** ☐ Yes ☐ No

How long has this bothered you? 1 2 3 4 5 6 7 ☐ Days ☐ Weeks ☐ Months ☐ Years

What treatments have you tried & have been effective? _____

_____

On a scale of 1-10 (1 = no pain & 10 = the worst) what is your level of pain? _____/ 10

The pain quality is: ☐ Burning ☐ Constant ☐ Dull ☐ Shooting ☐ Throbbing ☐ Sharp ☐ Tingling ☐ Other:_____

PLEASE READ AND SIGN: The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: ____/____/_____