<u>Welcome to Our Office</u>

Name ________________________________ DOB ____/____/_____ Age_____ Ht.____ Wt._____

Address ____ City_____________ Zip________

SSN __________ - _____ - __________ Email _______________________@_________________

Home (_____) _____ - ________ Work (_____) _____ - __________ Cell (_____) _____ - ________

Occupation ____________________________ Employer ________________________________

Marital Status _________________ Name of Spouse or Parent ____________________________

INSURANCE INFORMATION

Primary Insurance _____________________ Policy # ________________ Group # _____________
Policy Holder Information (If different from patient) Employer ____________________________

Name________________________ SSN _______ - ___ - _______ Insured DOB ____/____/_____

Supplemental Insurance Information
Company Name ___________________________ Policy # ________________ Group # ________

Name________________________ SSN _______ - ____ - _______ Insured DOB ____/____/____

MEDICAL INFORMATION

Name of Primary Care Physician _______________________________ Phone ________________

How did you hear about us? (Referral from Doctor, Friend, etc) ____________________________

What is your Foot/Ankle Problem? ____

____

Previous Footcare ____________________________ By Whom? _____________ When? _______
<u>Medical History</u>: Have you been diagnosed with any of the following? (Please Circle)

AIDS or HIV	Diabetes	Hepatitis	Stroke
Arthritis	Epilepsy	High Blood Pressure	Tuberculosis
Asthma	Emphysema	Lupus	Thyroid Disease
Bleeding disorder	Gout	Multiple Sclerosis	Ulcer/GERD (acid reflux)
Cancer	Heart Disease	Kidney Disease	OTHER:_____________

Current Medications: (Please list all) ____

____

____

Do you have any Drug or Food Allergies? Yes / No If Yes, please list ________________________

Please list any previous Surgery or Hospitalizations: ____

____

Please Circle One

Have you had a physical exam within the last 2 years?.............................. YES NO

If yes, name of physician___________________________________

Other (Any other information regarding your health that you feel is important to note):

____

Authorization: I do hereby grant permission to Bailey Foot & Ankle Specialists, PC to administer treatment upon myself as may be deemed medically necessary. I hereby authorize release to a third party payer (such as an insurance company or governmental agency) any medical records and/or condition concerning diagnosis and treatment in connection with a claim for payment for such a treatment and/or diagnosis. I permit a copy of this authorization to be valid as the original. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third party payer within a reasonable period of time, not to exceed 60 days.

____ __________________________

Signature Date

____ __________________________

Signature (Parent or Guardian) Date