



Metropolitan Ankle & Foot Care Specialists

Date: ___/___/___

Patient Name: _____ DOB: ___/___/___ Age: ___ Sex: M F

Home Address: _____ City: _____ State: _____ Zip: _____

Social Security#: _____

Please select how you prefer to be contacted:

Home Phone: (____) _____ - _____ YES NO

Cell Phone: (____) _____ - _____ YES NO

E-mail: _____ YES NO

Emergency Contact Info:

Name: _____

Phone #: _____

Relationship: _____

Do you have a legal guardian or healthcare power of attorney? YES NO

Is there a family member you would like for us to share your medical information?

___ YES Name: _____ Relationship: _____

___ NO

Marital Status: Single Married Partnered Separated Divorced Widowed

Employer: _____ Occupation: _____

Employer Address: _____

How much are you on your feet at work? 10% 50% 75% 100%

INSURANCE:

Health Primary: _____ Secondary: _____

Auto: _____ DOA: _____ Claim #: _____

Workman's Comp: _____ DOA: _____ Claim #: _____

YOUR MEDICAL HISTORY:

Referring Doctor: _____ Date Last Seen: _____ Phone #: _____

Primary Care Doctor: _____ Date Last Seen: _____ Phone #: _____

Pharmacy: _____ Location: _____ Phone #: _____

Quality Measures

Height: _____ Weight: _____ Shoe Size: _____

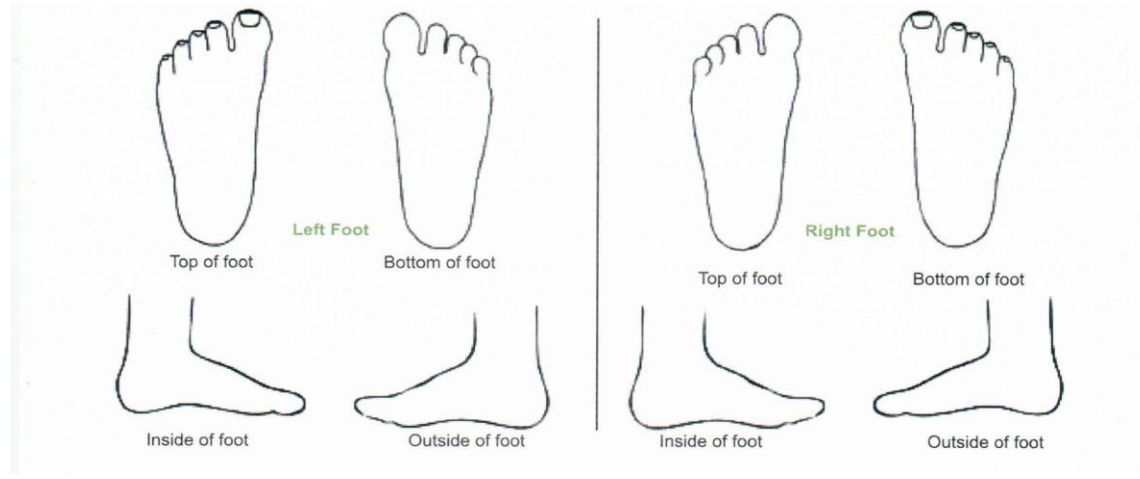
Smoking History: Never Quit, how long ago? _____ Current, how many packs per day? _____

Alcohol Use: Never Social Moderate Heavy Quit, how long ago? _____

Current Problems

What specific problem brings you to the office? _____

Where is the pain/problem located? **Please mark the pictures below.**



How Did You Hear About Our Practice? _____

If by referral, whom may we thank for referring you to the office? _____

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes to my medical status.

Print Name of Patient, Parent or Guardian

Signature

If Other Than Patient, Relationship to Patient

Date

Signature of Doctor

Date