SHORELINE FOOT AND ANKLE CENTER

Dr. Darren J. Courtright DPM, Dr. Sonya L. Marshall DPM, Dr. Dennis P. Claire DPM

Patient's Name: _____ ☐ Male ☐ Female Today's Date: _____
Please enter complete legal name

By what name would you like our office to address you? _____ Preferred Language: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Birthdate: _____ Age: _____

Social Security #: _____ Patient Status: ☐ Single ☐ Married (Name of Spouse _____) ☐ Widowed

Height:_____ Weight:_____ ☐ Partnered ☐ Other _____

Race: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Decline

Employer: _____ Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

We would like to know how you heard about us? _____

Your Pharmacy: _____
(Name & Address)

I authorize Shoreline Foot and Ankle Center to perform examination or treatment needed to diagnose and/or treat my foot/ankle problem. I also authorize the taking of and the use of clinical photographs. I understand that these x-rays are the property of Shoreline Foot and Ankle Center. I understand that I or the person responsible for paying my bills is financially responsible for charges not covered by my insurance. All insurance plans are not the same and do not cover the same procedures. In the event my health care plan determines a service to be "not covered", I will be responsible for the complete charge.

I request that payment of authorized benefits be made to Shoreline Foot and Ankle Center for any services furnished me by Shoreline Foot and Ankle Center. I authorize any holder of medical information about me to release to my insurance company and it's agents and information needed to determine these benefits or these benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 13 of the HCFA 1500 claim form in completed, my signature authorizes releasing of the information to the insurer or agency shown.

Signed: X_____ Date: _____
(insured or authorized person)

Primary Care Physician: _____ Location: _____

Date Last Seen: _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain_____

Have you had or do you now have allergies & type of reaction:

☐ Penicillin _____ ☐ Local Anesthesia _____ ☐ Sulfa Drugs _____
☐ Tape or Bandaids _____ ☐ Iodine _____ ☐ Foods _____
☐ Codeine _____ ☐ Aspirin _____ ☐ Silver _____
☐ Latex_____ ☐ Other _____

Have you had or do you now have or are you taking medication for any of the following: (Please check all that apply)

☐ Arthritis
☐ Asthma
☐ Alcoholism
☐ Back Problems
☐ Cancer_____(type)
☐ Diabetes
☐ Drug Addiction
☐ Ear Problems
☐ Elevated Cholesterol
☐ Epilepsy
☐ Eye problems
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ High Blood Pressure
☐ HIV Infection
☐ Hypothyroidism
☐ Hyperthyroidism
☐ Kidney Problems
☐ Liver Disease
☐ Neuro Disorder
☐ Neuropathy
☐ Polio
☐ Psychiatric Problems
☐ Respiratory Disease
☐ Sinus Problems
☐ Varicose Veins
☐ Vascular Disease
☐ Venereal Disease
☐ Ulcers – stomach
☐ Ulcers – foot
☐ Other _____

Please list any surgeries and/or hospitalization that you have had: (Please indicate procedure, date, where performed and attending physician, if known)

_____

_____

Please list names and dosages of any medication that you are currently taking (please include over-the-counter and vitamins):

_____

_____

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (include foot, ankle, knee, thigh and hip complaints.):

_____

_____

Have you ever been to a Podiatrist before? ☐ Yes ☐ No If yes, please list: _____

Is there any personal or family history of diabetes? ☐ Yes ☐ No

Tobacco use: ☐ Yes ☐ No
Alcohol use: ☐ Yes ☐ No

List athletic activities you participate in: _____

Please indicate which foot problems you now have or have had in the past: (Please check all that apply)

☐ Ankle Pain
☐ Cramps & Numbness
☐ Ingrown Toenails
☐ Athlete's Foot
☐ Flat Feet
☐ Plantar Warts
☐ Bunions
☐ Foot or Leg Cramps
☐ Swelling in Ankles & Feet
☐ Corns & Calluses
☐ Heel Pain
☐ Tired Feet

By signing below, I am certifying that this is my/the patient's complete medical history to the best of my knowledge.

Patient or Responsible Party: **X**_____ _____ _____

(Signature) *(Print)* *(Date)*