PARADISE VALLEY FOOT & ANKLE, PLLC

PATIENT DEMOGRAPHIC INFORMATION FORM

PLEASE FILL OUT EVERY SPACE. IF IT DOES NOT PERTAIN TO YOU, PLEASE WRITE N/A.

PATIENT

Patient's Name (Last, First, Middle Initial)		E-mail Address
Date of Birth	Social Security Number	Gender (Please circle) Male or Female
Address (Street, Apt. #, City, State, Zip Code)		Telephone Number
Occupation	Employer	Work Telephone
Height	Weight	Shoe Size

EMERGENCY CONTACT

Name	Relationship	
Address (Street, Apt. #, City, State, Zip Code)		Telephone Number

OTHER

Name of Primary Care Physician	Telephone Number
Pharmacy Name	Telephone Number
Location (Cross Streets)	
Who may we thank for referring you to this office?	

GUARANTOR IF OTHER THAN PATIENT

Please Note: Anyone under the age of 18 must be accompanied by a parent or legal guardian.

Name	Relationship	
Date of Birth	Social Security Number	
Address (Street, Apt. #, City, State, Zip Code)		Telephone Number

IF PRIMARY INSURANCE HOLDER IS NOT THE PATIENT

Name of Primary Insurance Holder	Relationship	Date of Birth

PLEASE REVIEW THE FOLLOWING; SIGN AND DATE BELOW:

I understand that I am responsible for any and all charges that my insurance deems to be patient responsibility. I understand that I am responsible for any and all charges that are denied by insurance. I authorize the release of information for insurance purposes concerning treatment of the above named patient. I authorize payment of any insurance benefits for medical or surgical service to Paradise Valley Foot & Ankle, PLLC. I authorize use of my signature for all insurance submissions. I am aware that there is a charge for missed appointments and late cancellations.

Signature:_____ **Date:**_____

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MEDICAL HISTORY FORM

PLEASE FILL OUT EVERY SPACE. IF IT DOES NOT PERTAIN TO YOU, PLEASE WRITE N/A.

Are you currently or have you ever been treated for:

Anemia	y / n	Circulation Problems	y / n	Kidney Disease	y / n
Anxiety	y / n	Depression	y / n	Liver Disease	y / n
Arthritis	y / n	Diabetes	y / n	Phlebitis	y / n
Asthma	y / n	Gout	y / n	Prolonged Bleeding	y / n
Bursitis	y / n	H.I.V.	y / n	Seizures	y / n
Cancer	y / n	Heart Problems	y / n	Stroke	y / n
If so, type_____		High Blood Pressure	y / n	T.B	y / n

Other _____

Do you have allergies to medications? y / n If so, please provide:

Medication Name	Reaction

Prescription medications you currently take:

Medication Name	Dose	Frequency

Over the counter medications you currently take:

Medication Name	Dose	Frequency

Family Medical History: (Add Relationship)

_____

_____

Do you exercise? y / n If so, what type(s)? _____

Do you smoke? y / n If so, how much?_____ How Long?_____

Do you drink? y / n If so, how much?_____

Recreational drug use? y / n If so, what type and quantity? _____

Surgical History

Procedure	Date

Do you have joint implants? y / n If so, where? _____

Have you had ANY trauma to your lower extremities? y / n If so, where? _____

Do you experience:

Difficulty with healing y / n If so, please explain: _____

Scarring y / n If so, please explain: _____

Leg cramping y / n If so, please explain: _____

Low back pain y / n If so, please explain: _____

Swelling in feet or legs y / n If so, please explain: _____

Numbness in feet or legs y / n If so, please explain: _____

What is your primary foot complaint? _____

Have you had any prior treatment for the above problem? y / n If so, please explain: _____

_____