Fenton Foot Care- 14229 Torrey Rd. Suite 1 Fenton, MI 48430

To submit prior to appointment, send via fax, 810-629-9243 or email, info@FentonFootCare.com

Patient Last Name | **Patient Legal First Name** | **Middle Initial**

Patient Date of Birth ____/____/____ | **Patient Social Security #** ____-____-____ | **Gender** ☐ Male ☐ Female | **Marital Status** ☐ Single ☐ Married ☐ Other

Address (No PO BOXs): Street | **City** | **State** | **Zip**

Home Phone (____)____-____ | **Cell Phone**** (____)____-____ | **Email:** _____

Occupation _____ **Employer** _____

Employment Status ☐ Full-Time ☐ Part-Time ☐ Retired ☐Unemployed ☐ Student

Emergency Contact Name _____ | **Relationship** ☐ Spouse ☐ Parent ☐ Other: _____ | **Best Phone Number** (____)____-____

Family Doctor _____ **Town** _____ **Office Phone** (____)____-____

How did you hear about our office? _____

What brings you in today (be specific): _____ **Duration**_____

Primary Ins Carrier: _____
Name of policy holder: _____
Policy Holder DOB: _____

Secondary Ins. Carrier: _____
Name of policy holder: _____
Policy Holder DOB: _____

Is your claim Auto or Work Comp ☐ YES ☐ NO | **If Yes, Date of Injury** | **Claim Number** | **Claim Rep Name** | **Rep Phone #**

Medicare Only: Are you enrolled in Hospice **Y**/ N Do you receive Home Health Care Y/ N Do you live in a nursing home Y/ N

Privacy Information

Where may we contact/leave you message(s): **HOME** ☐ YES ☐ NO **CELL** ☐ YES ☐ NO

Name of person(s) who can have access to your records/PHI or pick up items for you:

Name_____ Relationship _____
Name_____ Relationship _____
Name_____ Relationship _____

Attest

I do hereby attest that this information is true, accurate and complete to the best of my knowledge. I understand that any falsification, omission or concealment of any material fact may subject me to all fees for services and/or other liability. I also understand that I am to notify Fenton Foot Care immediately of any changes to the above information and annually upon the office's request. I also acknowledge that I have been provided the opportunity to take and review the office's HIPAA Policy, Authorization from Patient or Legal Representative, and Notification of Office Policies and Procedures (version01-01-2017). (Available in our waiting room and/ or by request). I further acknowledge and accept all the terms and conditions outlined in all forms listed including "notifications of office policies and procedures", "HIPAA policy notice of privacy practices", and "authorization from patient or legal representative". I authorize Fenton Foot Care to contact me via text and email. (MSG & date rates may apply)

_____ _____ _____ _____

Print Patient's Name or Legal Representative | Signature | Relationship to Patient | Date

CURRENT MEDICAL HISTORY

Patient Last Name _____ **Patient *Legal* First Name** _____

Patient Shoe Size _____**Weight** _____ **Height**_____ **Are you Diabetic** ☐Yes ☐No

Physician that follows your diabetic care _____ **Date last seen by them**_____

Current Conditions – mark NONE if the condition below does NOT apply to you

Symptoms: ☐**None** ☐Chills ☐Fever ☐Nausea ☐Vomiting

Neurological: ☐**None** ☐Numbness/ Nerve Pain ☐Seizures ☐Strokes

Skin: ☐**None** ☐Cellulitis/Infection ☐Fungal Nails ☐Ingrown Nails ☐Sores ☐Rash ☐Warts

Vascular: ☐**None** ☐Leg/Calf Cramping ☐Cold Feet ☐Leg/Calf Cramping at rest ☐Skin red/ pale / purple

Allergies – mark NONE if the allergies below do not apply to you

☐**None** ☐Adhesive/tape ☐Anesthetics ☐Aspirin ☐Blood thinners ☐Codeine ☐Dairy ☐Eggs ☐Erythromycin ☐Demerol ☐IV contrast dye ☐Iodine ☐Latex ☐Penicillin ☐Seafood ☐Sulfa ☐Other: _____

Current Medications

Medication List can be copied & attached separately if available – You do NOT have to rewrite medications

Medication	Dosage	How Often	Medication	Dosage	How Often
☐**None**					

Pharmacy you prefer to use

Pharmacy: _____ **Location:** _____ **Zip:** _____

Past Medical History – mark NONE if the history below does NOT apply to you

☐**None**	☐CAD	☐Gastric reflux	☐Liver disease	☐Seizures
☐AIDS/HIV·	☐Cancer (Type) _____	☐Glaucoma	☐Lung disease	☐Skin disease
☐Abnormal heart beat	☐ Chronic back pain	☐Gout	☐Multiple sclerosis	☐Stroke
☐Anxiety·	☐Chemotherapy	☐Heart attack	☐Neuropathy	☐Thyroid disorder
☐Asthma	☐Circulation problems	☐Hepatitis (Type___)	☐Osteoarthritis	☐ Ulcers/Sores
☐Bleeding disorder	☐Dementia	☐High Cholesterol	☐ Parkinson's disease	☐ Other _____
☐ Blood clot	☐Depression	☐High blood pressure	☐ Rheumatoid arthritis/ autoimmune disease	_____
	☐Diabetes	☐Kidney disease		

Social History

Smoking History ☐ Non-Smoker
☐ Current Smoker
Packs per day _____
☐Former smoker
Years of cessation _____

Alcohol History
☐**None**
☐Social
☐Occasional
☐Heavy

Family History

Place An "X" on all applicable lines	**Father**	**Mother**	**Both**
No significant family medical conditions	____	____	____
Unknown family history	____	____	____
Diabetes	____	____	____
Heart Attack	____	____	____
Cancer	____	____	____
Other _____	____	____	____

Peripheral Artery Disease (PAD) Questionnaire and Fall Questionnaire

Patient Last Name	Patient Legal First Name	Middle Initial	DOB

Do your legs ever feel tired causing you to stop and rest?	Yes	No
When you walk do you ever have to stop because you have pain or cramping in your calves or thighs?	Yes	No
Do you ever experience cramping, tightness, “charlie horses” or pain in the legs or feet when lying down that improves when you stand up?	Yes	No
Do you have any wounds, cuts, or sores that are not healing on your feet or toes?	Yes	No
Is the skin on your legs or feet pale, reddish or purple?	Yes	No
Is the skin on your legs or feet cool to the touch?	Yes	No
Have you ever been told you have diabetes? Even borderline diabetes?	Yes	No
Has anyone ever told you that you have poor circulation in your legs, intermittent claudication or peripheral arterial disease?	Yes	No
Have you ever had any testing done to your legs for these diseases?	Yes	No
Do you use a walker, cane, or other assistive device when walking?	Yes	No
Do you feel unstable when you walk?	Yes	No
Have you fallen in the past, or had a “near fall” in past?	Yes	No

_____	_____	_____	_____
Print Patient’s Name or Legal Representative	Signature	Relationship to Patient	Date