



Paul D. Reynolds, DPM

PATIENT INFORMATION

Name _____ (First) _____ (Last) _____ (MI) Date _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email _____ SSN _____ D.O.B. _____
Height: _____ Weight: _____ Sex: **M F** Marital Status: **Single Married Windowed Divorced Separated**
Who referred you to our office? _____ Who is your primary physician? _____
Employer _____ Spouse's Name _____

if patient is a minor, parent or guardian please complete

Parent Name _____ Relationship _____
Home Phone _____ Work Phone _____ Cell Phone _____
Employer _____

EMERGENCY CONTACT

Name _____ Phone _____ Relationship _____

INSURANCE INFORMATION

Primary Insurance Company _____ Policy # _____
Policy Holder _____ DOB _____
Secondary Insurance Company _____ Policy # _____
Policy Holder _____ DOB _____

INSURANCE AUTHORIZATION: I request that payment of authorized benefits be made to the above facility on my behalf, for any services provided to me. I authorize any holder of medical and other information about me can be released to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, or any other information needed to determine benefits for related services. I agree to pay for all charges not covered by my insurance. I authorize a copy of this authorization to be used in place of the original document.

Signed _____ Date _____
(patient or person authorized to consent for patient)

MEDICAL INFORMATION

INFORMATION ABOUT CURRENT PROBLEM

Describe your foot/ankle problem _____

How long has it bothered you? _____ Please rate your pain 1 2 3 4 5 6 7 8 9 10
Mild Severe

What makes your condition worse? _____

What makes your condition better? _____

Have you tried to treat this condition? (soaks, pads, changing shoes, medications) YES NO

If YES, please explain _____

Have you been treated by another doctor for this problem? YES NO If so, who? _____ when? _____

GENERAL HEALTH INFORMATION

Tobacco use? YES NO

Do you drink alcohol or beer? YES NO

PATIENT MEDICAL HISTORY

Check all that you HAVE or HAVE HAD a problem with:

| | | | |
|---|---|--|---|
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Pain (feet/leg) | <input type="checkbox"/> Diabetes (IDDM) |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Diabetes (NIDDM) | <input type="checkbox"/> Cholesterol Problems |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> GERD/Reflux | <input type="checkbox"/> Lupus Erythematosus | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Abnormal Bleeding |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Foot Ulcers | <input type="checkbox"/> Burning/Numbness | <input type="checkbox"/> Blood Clots |

CURRENT MEDICATIONS

DRUG ALLERGIES

FAMILY HISTORY

Please list any family medical history:

| | |
|--|-----------------|
| <input type="checkbox"/> Cancer | Relation: _____ |
| <input type="checkbox"/> Heart Disease | Relation: _____ |
| <input type="checkbox"/> High Blood Pressure | Relation: _____ |
| <input type="checkbox"/> Diabetes | Relation: _____ |
| <input type="checkbox"/> Depression/Mental Disorders | Relation: _____ |
| <input type="checkbox"/> Other _____ | Relation: _____ |