WELCOME TO OUR OFFICE TODAY'S DATE: ____________________
In order to serve you better, we need the following information.
All information is strictly confidential. How did you hear about us? ________________________

Patient's Name____Birthdate:___________________________
(Last) (First) (Middle) (Month, Day, Year)

SSN:________________________Sex: M F Height _____________ Weight________ Shoe Size______________

Address_______________________________City___________________________Zip Code _________________________

Home Phone (_____) _______________Work Phone_____________________________ Cell ___________________________

How would you like to be contacted: Home Phone/Cell Phone/Work Phone/Mail/E-mail?

Email address: ____

Name of Spouse/Parent/Sig. Other ____Marital Status: M/S/D/W/SEP/Sig Other

Name of Insured ____________________________________ Relationship ___________ Date of Birth ___________________

Preferred Language: English/Spanish/Other ________ Race: American Indian/Asian/African American/White/Other____________

Ethnicity: Hispanic-Latino/ Not Hispanic or Latino

Why are you here today? ____

How long has this bothered you? _______________What have you done to treat the problem? ____________________________

Do you currently wear orthotics? Yes____ No ______Do you have arch support problems? Yes _____ No_____

Ingrown toenails? Yes/No Diabetic? Yes/ No_____ If diabetic do you take insulin? Yes/No Last HBA1C _____ Last glucose # _______

Last Arterial Lwr Extremity Doppler (PVR) report, with waveforms: ____________ Have you had Nutritional Counseling for Diabetes? Yes/No

Cholesterol: ___________

Family Physician: ______________________________Date last seen______________ Phone #______________May we contact? ____

Pharmacy:______________________Phone #_____________Current Conditions you are being treated for: _________________________

List ALLERGIES to medications, if any: ____ NO ALLERGIES

Please list all surgeries you have had ____

List any medications you are taking, even over the counter, INCLUDING DOSAGE (if you have a list please give to receptionist and skip this question) ____

CIRCLE ANY CONDITIONS YOU HAVE HAD IN THE PAST: None of the below___

Anemia	Cancer	Hearing Problems	Nerve problems
Arthritis	Circulation Problems	Hepatitis	Phlebitis
Asthma	Eye Disease	Mononucleosis	Rheumatism
Bleeding Problems	GI Disorders	Neck Stiffness	Skin Problems
Calf Pain	Gout		

FAMILY HISTORY: Indicate Relationship-Mother(M)/Father(F)/Sibling(B/S) None of the below ___

Arthritis	Bunions	Diabetes	Gout	Heart Disease
Bleeding Disorder	Circulation Problems	Flatfeet	Hammertoes	Stroke

SOCIAL HISTORY:

Athletic/What type of sport? _________________ Drink Alcohol? Yes/No How much? _____________________

Smoker-Current # per day______ Previous Smoker ____ Never Smoked ____ Recreational drug use? Yes/No

Peripheral vascular disease (PVD) is a common circulation problem in which the blood vessels, which carry blood to the legs or arms, become narrow or clogged. Please answer the following questions to see if you have symptoms of Peripheral Vascular Disease. Circle Yes or No

1. When you walk or exercise, do you experience aching, cramping or pain in your arms, legs, thighs or buttocks? YES NO
2. If you answered yes, does the pain subside with rest? YES NO

   What part of your body do you feel pain:____
3. Do you have any painful sores or ulcers on your legs or feet that aren't healing? YES NO
4. Do you have Diabetes? YES NO
5. Have you experienced TEMPORARY:

   Loss of vision in one eye? YES NO

   Slurred speech? YES NO

   Weakness or numbness of an arm or leg on one side of your body? YES NO
6. Have you had surgery, balloon procedures, or stents to any blood vessels other than you heart? YES NO
7. Have you had blockages in your coronary arteries? YES NO
8. Do you have (circle all that apply):

   High Cholesterol   History of Smoking   High Blood Pressure

Occupation: ________________________ Do you stand? Yes No Sit: Yes No Both Employer's Name:____________________________

INSURANCE AUTHORIZATION AND ASSIGNMENT/FINANCIAL AGREEMENT

I HEREBY AUTHORIZE CONNIE L. BILLS, D.P.M., TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS AN INSURANCE CLAIM AND FUTHER AUTHORIZE PAYMENT DIRECTLY TO THIS PHYSICIAN FOR ANY SERVICES RENDERED AND NOT PAID FOR BY ME. **NOTICE: ROUTINE CARE OF TOENAILS, CORNS AND CALLUSES ARE NOT A MEDICARE COVERED SERVICE.** ANY CO-PAYMENTS OR DEDUCTIBLES ARE PAYABLE AT THE TIME OF VISIT. I UNDERSTAND THERE IS NO GUARANTEE THAT MY INSURANCE COMPANY WILL PAY FOR MY OFFICE VISIT OR ANY MEDICAL SUPPLIES THAT MAY BE SUPPLIED. IF I AM BILLED FOR ANY AMOUNT MY INSURANCE DOES NOT COVER, I UNDERSTAND THE FULL AMOUNT IS DUE WITHIN 30 DAYS UNLESS PAYMENT ARRANGEMENTS ARE MADE WITH THIS OFFICE. IF PAYMENT IS NOT RECEIVED, THIS OFFICE WILL TAKE NECESSARY MEASURES FOR COLLECTION AND A 33% FEE RELATED TO THE COLLECTION OF MONIES WILL BE ADDED TO THE AMOUNT PAYABLE. YOU MUST GIVE THIS OFFICE 24 HOURS NOTICE OF CANCELLATIONS OF APPOINTMENTS OR A $ 50.00 CHARGE WILL BE BILLED TO YOU.

_______________________________________   ______________________________

SIGNATURE OF PATIENT OR GUARDIAN   DATE