

PUT YOUR FEET FIRST, P.C
Mark D. Forman, D.P.M David M. Bates, D.P.M

PATIENT INFORMATION

Today's Date: _____
Patient's Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Cell Phone: (____) _____
Best Number to Reach you: _____ Can we leave a message? _____
Social Security #: _____ Sex: Male __ Female __ Marital Status M S D W
Patient's Employer: _____ Work Phone: _____
Business Address: _____ Occupation: _____
Responsible Party: _____ Relation: _____
Phone #: (____) _____ Date of Birth: _____ Social Security #: _____
Primary Care Physician (PCP)/other: _____ Phone: (____) _____
Referred by: _____ Date of last physical: _____ By whom: _____
Emergency Contact-Name: _____ Phone: (____) _____
Pharmacy: _____ Phone Number: (____) _____

INSURANCE INFORMATION
(Please complete all insurance information)

Primary Insurance Information

Secondary Insurance Information

Insurance Name: _____	Insurance Name: _____
Policy Holder: _____ DOB: _____	Policy Holder: _____ DOB: _____
ID# _____ Group # _____	ID# _____ Group # _____
Employer: _____	Employer: _____

Is this a work related injury? ___ **If yes, date of injury:** _____ **Carrier:** _____

Claim# _____ **Adjuster:** _____ **Phone#** _____

ASSIGNMENT OF BENEFITS: I authorize the release of information necessary to process this claim and hereby assign my insurance benefits to be paid directly to Mark Forman, DPM, and David Bates, DPM. I acknowledge financial responsibility for services, which are not covered by my insurance company.

CONSENT FOR MEDICAL TREATMENT: I authorize Mark Forman, DPM and David Bates, DPM to provide medical care including but not limited to diagnostic examinations; radiological, laboratory testing, and necessary medical treatment.

Signature: _____ **Date:** _____

PODIATRIC HISTORY

ALLERGIES:

(Please indicate what reactions these cause.)

<input type="checkbox"/> None _____	<input type="checkbox"/> Aspirin _____	<input type="checkbox"/> Codeine _____	<input type="checkbox"/> Cortisone _____
<input type="checkbox"/> Iodine _____	<input type="checkbox"/> Latex _____	<input type="checkbox"/> Local Anesthetic _____	<input type="checkbox"/> Sulfa _____
<input type="checkbox"/> Penicillin _____	<input type="checkbox"/> Tape: _____	<input type="checkbox"/> Other: _____	

CURRENT MEDICATIONS

Drug Name: Dose: Prescribing Doctor

PAST SURGERIES/HOSPITALIZATIONS

(Please indicate the year)

Please indicate which problems you now have or have had in the past.

Ankle Pain	YES	NO	Flat Feet	YES	NO	Ingrown toenails	YES	NO
Athletes Foot	YES	NO	Foot/leg cramps	YES	NO	Plantar Warts	YES	NO
Bunions	YES	NO	Heel Pain	YES	NO	Tired Feet	YES	NO
Corns	YES	NO	Numbness in feet	YES	NO	Swelling in Ankles	YES	NO
Calluses	YES	NO	Numbness in legs	YES	NO	Swelling in Feet	YES	NO
Burning in Feet	YES	NO	Trouble Walking	YES	NO	Varicose Veins	YES	NO

PRESENT MEDICAL HISTORY

Please circle the appropriate box.

Asthma	YES	NO	Hepatitis A	YES	NO	Liver Disease	YES	NO
Bleeding Problem	YES	NO	Hepatitis B	YES	NO	Specify:		
Specify:			Hepatitis C	YES	NO	Lung Disease	YES	NO
Cancer	YES	NO	Heart Disease	YES	NO	Specify :		
Specify:			Specify:			Neurological Problems	YES	NO
Diabetes	YES	NO	High Blood Pressure	YES	NO	Specify:		
Specify:(Diet/Pills/Insulin)			High Cholesterol	YES	NO	Osteoarthritis	YES	NO
Fibromyalgia	YES	NO	HIV	YES	NO	Rheumatoid Arthritis	YES	NO
Gout	YES	NO	Migraines	YES	NO	Ulcers	YES	NO
Head Trauma	YES	NO	DVT/blood clots	YES	NO	Specify:		
Stroke/CVA/TIA	YES	NO	Kidney Disease	YES	NO	Thyroid Disease	YES	NO

PODIATRIC HISTORY

Height _____ Weight _____ Shoe Size _____

What is the reason for your visit today? _____

What time of day is the pain felt most? AM PM

Have you ever been to a podiatrist before? YES / NO

If yes, please list: Name of Podiatrist: _____ Last Visit: _____

Do you exercise frequently? YES / NO

Please indicate the athletic activities in which you participate:

Walking ___ X week Swimming ___x week Biking ___x week
 Jogging/Running ___x week Hiking ___x week Other: _____

Is there any personal or family history of cardiac disease? YES / NO Relation: _____

Do you see a cardiologist? YES / NO

If yes, name: _____ Phone Number: _____

VASCULAR HISTORY

Do you now or have you ever smoked tobacco? YES / NO

If yes, how often? Check one: ___ Abstinence 1-10 years
___ None Currently and Abstinence > 10 years
___ Currently Smoke < 1 pack per day/ Abstinence < 1 year
___ Currently smoke > 1 pack per day

Do you have high blood pressure? YES/ NO

If yes, how is it controlled? Circle one: 1 med 2 meds > 2 meds or uncontrolled

If you know it, what is your normal blood pressure? _____

Do you have diabetes? YES / NO

If yes, how old were you when you were first diagnosed with diabetes? _____

Do you take insulin to control your blood sugar? YES NO

Do you take pills to control your blood sugar? YES NO

Is there any personal or family history of diabetes? YES / NO Relation: _____

Do you have high cholesterol? YES / NO

If yes, how do you control it? Check one: ___ Mild Diet Restrictions
___ Strict Diet Restrictions
___ Medication

Does your family have a history of vascular disease? YES / NO

If yes, please list the relationship of the family member and their complications:

Relationship:	Complication:
_____	_____
_____	_____

Chronic Venous Insufficiency Questionnaire:

Chronic Venous Insufficiency (CVI) is a serious circulatory problem in which the leg veins cannot pump enough blood back to your heart. It affects over 2.5 million Americans, most over the age of 40. Symptoms of CVI include varicose veins, skin problems, leg and ankle swelling, tight calves, and legs that feel heavy, tired, restless, or achy. Factors that can increase the risk of CVI include pregnancy, obesity, smoking, standing or sitting for long periods of time and not getting enough exercise. Answers to these questions will determine if you are at risk for CVI and if a vascular exam will help us better assess your vascular status.

Circle “YES” or “NO”

1. Are your legs swollen, painful, red or warm to touch? YES / NO
2. Have you had a blood clot in a vein that caused inflammation, pain or irritation? YES / NO
3. Do you have varicose veins (veins that are enlarged or swollen and raised above the surface of the skin) in the legs? YES / NO
4. Have you had a Deep Vein Thrombosis (DVT) in the past and are experiencing pain, swelling, changes in the skin color, cellulitis, or non-healing ulcers? YES/NO
5. Do your legs feel heavy, tired, restless or achy? YES / NO
6. If you push on your swollen foot, ankle or leg for 10 seconds and release, does your fingerprint leave a dimple? YES / NO
7. If your feet, ankles and legs are swollen, does the skin look stretched or shiny? YES / NO
8. Do you have an ulcer on the inside of your ankle? YES / NO

Peripheral Arterial Disease (PAD) Questionnaire:

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It may result in leg discomfort when walking, poor healing of leg sores/ulcers, difficulty in controlling blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack.

Circle “YES” or “NO”

1. Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain)when you walk which is relieved by rest? YES / NO
2. Do you experience any pain at rest in your lower leg(s) or feet? YES / NO
3. Do you experience foot or toe pain that often disturbs your sleep? YES / NO
4. Are your toes or feet pale, discolored, or bluish? YES / NO
5. Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)? YES/ NO
6. Has your doctor ever told you that you have diminished or absent pedal (foot) pulses? YES / NO
7. Have you suffered a severe injury to the leg(s) or feet? YES / NO
8. Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? YES / NO

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT AND
ACKNOWLEDGEMENT OF RECEIPT OF PYFF, P.C.'S
NOTICE OF PRIVACY PRACTICES

- I will pay all co-pays prior to being seen by the doctors unless arrangement has been made.
- If my insurance requires referrals for office visits, I take full responsibility to obtain them prior to my appointment. If this is not done, I agree to pay all claims denied because of lack of proper referral or I may choose not to be seen until a referral is received.
- I understand that some items and/or procedures authorized by my insurance does not guarantee payment and may later be denied and not paid. I accept financial responsibility for these items if they are denied even though proper authorization is obtained. I also understand that these items cannot be returned.
- I understand that a \$30.00 returned check fee will be charged for all returned checks.
- I understand that \$25.00 fee may be charged for all disability paperwork.
- I understand that \$ 25.00 fee may be charged for all missed appointments. We require at least a 2 hour notice if for any reason you cannot make your appointment.
- I understand that if I change my insurance, I am responsible to notify PYFF.
- I understand that there can be a charge for printing medical records.
- I agree that this account will be “paid-in-full” upon presentation of the statement. Any courtesy fees are only extended predicated upon full-payment of fees at the time of visit. If this account is not paid-in-full upon presentation of the statement, I agree to pay a monthly re-billing fee of \$3.00 per month until paid. In the event the account is turned over to an attorney or collection agency, I agree to pay any and all actual collection charges and/or attorney’s fees incurred in an amount not to exceed 50% of the balance due. I further agree that the jurisdiction for any action filed for the purpose of collection any sums due on this account shall be the place where the contract was made, specifically Maricopa County, Arizona. A photocopy for facsimile of this assignment shall be considered as valid as the original.
- I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Signature of responsible party: _____ Date: _____

Printed Name of responsible party: _____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian personal representative, etc.)