

# WELCOME TO OMAHA FOOT AND ANKLE SPECIALISTS!

Please take a few moments to CAREFULLY AND LEGIBLY fill out the following information. THANK YOU!

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Soc. Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Home Ph. #: \_\_\_\_\_ Work Ph. #: \_\_\_\_\_ Cell Ph #: \_\_\_\_\_

MESSAGES MAY BE LEFT AT THE NUMBER(S) LISTED IN REGARDS TO :  APPOINTMENTS  MEDICAL INFO./ RESULTS

PLEASE CIRCLE: Marital Status: S / M / D / W Sex: M / F Ethnicity: Not Specified Hispanic/Latino Not Hispanic/Latino

Race: Not Specified American Indian/Alaska Native Asian Black/African American Native American White

Employment:  Full-Time  Part-Time  Retired  Unemployed

Employer: \_\_\_\_\_

## EMERGENCY CONTACT

Address: \_\_\_\_\_

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Occupation : \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

IF YOU ARE NOT THE POLICY HOLDER FOR YOUR INSURANCE, PLEASE FILL OUT THE FOLLOWING:

PLEASE CHECK ONE:  PRIMARY INSURANCE  SECONDARY INSURANCE

Insured's Last Name: \_\_\_\_\_ Insured's First Name: \_\_\_\_\_

Insured's Soc. Security #: \_\_\_\_\_ Insured's D.O.B.: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

**GUARANTOR INFORMATION: Person responsible for your medical bills (PLEASE fill in or write 'SELF'):**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Did he/she refer you here?: \_\_\_\_\_ Date of last visit: \_\_\_\_\_ Date of last History & Physical: \_\_\_\_\_

Other Medical Specialists: \_\_\_\_\_

Other Podiatrists seen: \_\_\_\_\_

What were you treated for?: \_\_\_\_\_

Please state in your own words the reason for today's visit: \_\_\_\_\_

How did you hear about our office?: \_\_\_\_\_

Today I will be paying for the visit by: \_\_\_\_\_ INSURANCE \_\_\_\_\_ CASH \_\_\_\_\_ CHECK \_\_\_\_\_ CREDIT CARD

## MEDICAL HISTORY

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

Previous Surgeries: \_\_\_\_\_

Hospitalization(s)/Serious Illness(es)/Accidents(s): \_\_\_\_\_

Previous Foot Conditions: \_\_\_\_\_

**Allergies:** \_\_\_\_\_

Medications (including prescriptions, over the counter medications and vitamins): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you smoke?  Yes  No If yes, \_\_\_\_\_ packs per day? How long have you been smoking? \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, what do you drink? \_\_\_\_\_ Drinks per day: \_\_\_\_\_

Please mark the appropriate box and if applicable, detail any specific problems you have had.

YES	NO	CONDITION	SPECIFIC PROBLEMS
		Weight Gain/Loss	
		Vision Trouble	
		Asthma	
		High Blood Pressure	
		Thyroid	
		Diabetes	
		Skin Conditions	
		Liver Problems	
		Bleeding Problems	
		Heart Condition	
		Circulation Disorders	
		Chest Pain	
		Lungs (TB, Pneumonia)	
		Swelling in legs, ankles and/or feet	
		Stomach Problems	
		Arthritis (if so, what type?)	
		Stroke(s)	
		Gout	
		Numbness in legs/feet	
		Muscle Cramping	
		Lower Back Pain	
		Depression	
		Psychiatric Issues	
		Kidney Stones	
		Other Illnesses or Problems	

**FAMILY HISTORY:** Please indicate if any of your immediate family members have had the following health related issues:

Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_ Stroke \_\_\_\_\_ Arthritis \_\_\_\_\_

Kidney Disease \_\_\_\_\_ Cardiovascular Disease \_\_\_\_\_ Mental/Emotional Disorders \_\_\_\_\_

I have read this form and answered the questions to the best of my ability. I authorize Dr. Cullen and Dr. Pachman to examine and treat me. I also authorize Omaha Foot and Ankle Specialists to furnish any and all information to my insurance company in regards to this appointment and all subsequent appointments I have at this office. I acknowledge that I am responsible for payment in full for services rendered.

Signature \_\_\_\_\_

Date \_\_\_\_\_