VICTORIA FOOT & ANKLE CENTER

WELCOME TO OUR OFFICE

(Please print and complete the following form)

Date: ____/____/____ Social Security: ____-___-____ Age: _____ .
Birthdate: ____/____/____ Email: _____ .

Patient Name: _____ Sex: Male / Female
Last First MI

Mailing Address: _____ .
City State Zip
Home #: _____ Cell Phone #: _____ Preferred Contact: _____ .
Employer: _____ Occupation: _____ .

Married / Widowed / Single / Separated / Divorced Student: Y / N School: _____ .

Spouse's Name: _____ Spouse's Birthday ____/____/____ .
Spouse's Employer: _____ Occupation: _____ .
Emergency Contact: _____ Phone Number: _____.

Whom may we thank for referring you? _____ .

Family Physician: _____ Phone #: _____ Last Visit:_____.

Pharmacy: _____ Phone #: _____ .

Shoe Size: _____ Height: _____ Weight: _____ .

Medical History:

- AIDS/HIV
- Anemia
- Arthritis
- Artificial Joint
- Blood Clots / DVT
- Cancer
- Chest Pains
- Circulation Problems
- COPD / Tobacco Use
- Diabetes
- Epilepsy
- Foot/Leg Cramps
- Gout
- Heart Disease
- Hemophilia
- Hepatitis
- High Blood Pressure
- Kidney Problems
- Liver Disease
- Low Blood Pressure
- Neuropathy
- Phlebitis/Varicose Veins
- Respiratory Disease
- Stroke
- Swelling in Ankle/Feet
- Ulcers

Allergies:

- Adhesive Tape
- Aspirin
- Codeine
- Iodine (seafood)
- Latex
- Penicillin
- Sulfa
- None
- Other (specify)

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History of Symptoms

(Please answer the following questions to the best of your ability.)

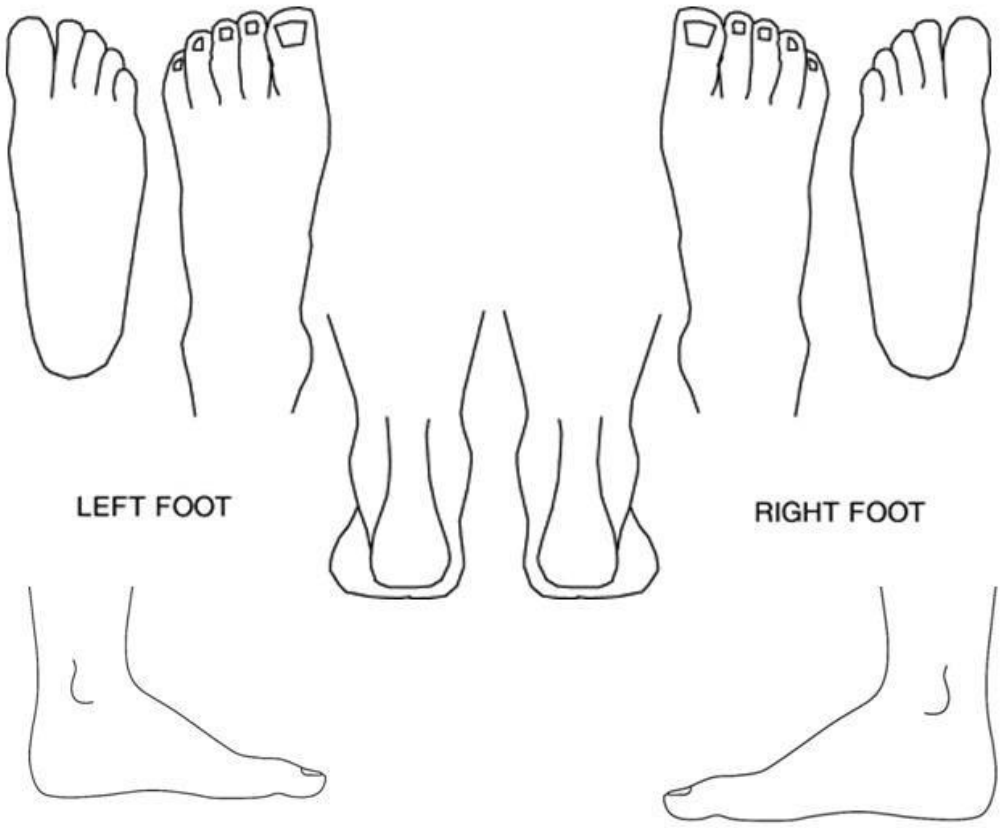
1. What is the main reason for your visit? _____
_____
_____

2. How long have your symptoms been present? If more than one episode, please list date of most recent episode.
_____
_____
_____

3. What treatments have you done thus far to alleviate your pain? _____
_____
_____

4. On a scale of 1-10, 10 being the worst pain of your life, how would you rate your pain? _____

5. Please circle the area(s) below that are bothering you today.



Medication List:

Medication:	Strength:

INITIALS _____ I understand that insurance is a contract between myself and the insurance company and that the doctor does not determine any amount that insurance will pay on my account. The fee for service is due to the doctor regardless of any action by the insurance company.

INITIALS _____ I understand that the information sent to me via email and/or text message from persons at VICTORIA FOOT & ANKLE CENTER, will not be sent securely and will be unencrypted. I understand the risks associated with that including, but not limited to, that my PHI may be read by an unintended third party.

I have been notified of these risks. I understand said risks and I still prefer to receive protected health information via unsecure communications email and text message. I understand that VICTORIA FOOT & ANKLE CENTER and its staff are not responsible for any unauthorized access of my protected health information communicated by way of unencrypted email and text and that I bear the risk.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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 choose) and understood the Notice.

PATIENT NAME _____

SIGNATURE _____

PARENT OF PATIENT _____ DATE: _____

(IF APPLICABLE)