PEORIA FOOT & ANKLE®
DOCTORS OF PODIATRIC MEDICINE

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PATIENT INFORMATION

DATE: _____

FIRST NAME

LAST NAME

Date Of Birth ____/____/____ **Gender** ☐ Male ☐ Female

Address _____

Phone Number _____ **Mobile** _____

Work Number _____ **Social Security Number** _____

Email _____

REASON FOR YOUR APPOINTMENT TODAY

Responsible Party (if minor) _____

Responsible Party Address: _____

Responsible Phone Number: _____

Status ☐ Single ☐ Married ☐ Divorce ☐ Widowed ☐ Separated

EMERGENCY CONTACT DETAILS

Contact Name _____ **Home Number** _____

Relationship _____ **Mobile Number** _____

MEANINGFUL USE: (FOR INTERNAL USE)PLEASE SELECT ONE:

☐ **American Indian** ☐ **Asian** ☐ **Black** ☐ **Hispanic or Latino** ☐ **Pacific Islander**

☐ **White** ☐ **Other** **Primary Language** _____

INSURANCE INFORMATION

Please remember to bring your insurance card to your visit!

Primary Insurance _____ **Policy Holder** _____

Relationship To Patient _____ **Group Number** _____

ID Number _____ **Policy Holder Date of Birth** _____

If you hold a secondary insurance, please provide all the additional information in the section below.

SECONDARY INSURANCE (If applicable)

Secondary Insurance _____ **Policy Holder** _____

Relationship To Patient _____ **Group Number** _____

ID Number _____ **Policy Holder Date of Birth** _____

HEALTHCARE PROVIDER INFORMATION

Current Healthcare Provider / Family Doctor _____

Provider Contact Phone Number _____

Former Podiatrist _____

ACCIDENT INFORMATION (If condition is not result of accident enter NA)

Date of Accident _____ **How / Where** _____

Work Related ☐ Yes ☐ No **Were you treated by another Doctor for this injury?** ☐ Yes ☐ No

Doctor's Name and Phone Number _____

HOW DID YOU HEAR ABOUT US?

☐ Internet / Search Engine ☐ Doctor Referral ☐ Friend Referral

☐ Social Media ☐ Review (Google, Yelp, Etc) ☐ Other

By Signing this document:

1. I hereby give my permission to administer treatment, and to perform such procedures as may be necessary in diagnosis and treatment. I will furnish insurance forms & information and I agree to pay my co-payment, deductible and non-covered portions at the time of my visit or when billed by the office.
2. *Minors* I agree that I am the legal guardian of this patient, and understand that only the legal guardian is allowed in the exam room.
3. I understand that a photograph may be taken of me for insurance verification purposes, and if I disagree with this process I will let the office know.
4. By providing your email address, you acknowledge and consent to receive secure electronic communications from Peoria Foot and Ankle, *a Division of Alliance Medical Specialists,* and its affiliates. These communications may include, but are not limited to, appointment reminders, billing statements, patient portal access details, and occasional marketing messages related to our services.

Signature Agreement Patient Signature (Please Sign Your Full Name Below)

Patient Signature: _____ Date:_____

MEDICAL HISTORY

PEORIA FOOT & ANKLE®
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Patient Name: (LAST, FIRST, MI.)_____

MEDICATIONS: Please list ALL medications (prescription and non- prescription) that you take and the dosage:

MEDICATION: _____ MEDICATION: _____ MEDICATION: _____

MEDICATION: _____ MEDICATION: _____ MEDICATION: _____

ALLERGIES

List all Allergies to Medications and the type of Reaction

_____

_____

PREVIOUS SURGERIES: (ADDITIONAL ON BACK)

TYPE: _____ YEAR: _____ TYPE: _____ YEAR: _____

TYPE: _____ YEAR: _____ TYPE: _____ YEAR: _____

PERSONAL MEDICAL HISTORY

Have you ever had any of the following conditions? (Check if yes)

- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Asthma
- ☐ Kidney Disease
- ☐ Hepatitis -Check Type ☐ A ☐ B ☐ C
- ☐ Thyroid Problems
- ☐ Heart Problems (Type_____)
- ☐ Liver Trouble
- ☐ Aids/HIV
- ☐ Diabetes (List Last Blood Sugar below: HbA1c:)_____
- ☐ Gout
- ☐ Varicose Veins
- ☐ COPD
- ☐ Arthritis (Type _____)
- ☐ Anemia
- ☐ Stroke
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Stomach Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol

Other: _____

FAMILY HISTORY (SELECT ALL THAT APPLY)

☐ Hypertension	☐ Mother	☐ Father	☐ Grandparent	☐ Sibling
☐ Heart Disease	☐ Mother	☐ Father	☐ Grandparent	☐ Sibling
☐ Diabetes	☐ Mother	☐ Father	☐ Grandparent	☐ Sibling
☐ Foot Problems	Mother	☐ Father	☐ Grandparent	☐ SIbling

SELECT ONE:

Tobacco use : ☐ Y ☐ N Amount _____ Have you quit? ☐ Y ☐ N

Alcohol use : ☐ Y ☐ N Amount _____

Drugs use : ☐ Y ☐ N

Do you have low back pain? ☐ Y ☐ N

Are you currently pregnant? ☐ Y ☐ N Number of Months: _____

Height _____ Weight: _____ Shoe Size: _____

*I understant that hones and complete answers to each question stated above are important to the provision of my medical care, and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form, I should ask the doctor or member of the medical staff for assistant. This information is true and accurate to my knowledge.

Patient Signature: _____ Date:___/___/___