

Name: Patient New DOB: _____ Chart Number: 3377
 Sex: ☐ M ☒ F Marital Status: ☐ Single ☒ Married ☐ Widowed ☐ Divorced SS#: _____
 E-mail: _____ Spouse/Partner Name: _____
E-mail newsletters, reminders, statements, etc.
 Address: _____ City: _____ State: _____ Zip: 00000
 Home #: _____ Cell #: _____ Other #: _____
 Employer: _____ Phone: _____
 Employer Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Are you the insured? ☐ Yes ☐ No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐ Spouse ☐ Child ☐ Self ☐ other
 Phone #: _____ Sex: ☐ Male ☐ Female DOB: ____/____/____
 Address: _____
 Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? ☐ Yes ☐ No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐ Spouse ☐ Child ☐ Self ☐ Other
 Phone #: _____ Sex: ☐ Male ☐ Female DOB: ____/____/____
 Address: _____
 Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend
☐ Other: _____

What is the reason for your visit today? _____

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ____/10

The pain quality is: ☐ burning ☐ constant ☐ dull ☐ sharp ☐ shooting ☐ throbbing ☐ tingling Other: _____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____

Date: _____

History and Physical

Name: Patient New

DOB: _____

Chart Number: 3377

Medical History: ☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy (specify) _____ ☐ Thyroid disease (specify) _____ ☐ Diabetes (type 1, type 2)
☐ Arthritis (specify) _____ ☐ other (specify) _____ ☐ HIV ☐ CVA
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke

Surgical History ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No
If yes, please describe: _____

Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History

Do you smoke? ☐ Yes ☐ No If yes how many packs per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 For how long? _____

Do you drink alcohol? ☐ Yes, everyday (5-7 days/week) ☐ Yes, occasionally/socially ☐ No/Rarely

Substance abuse: ☐ Yes, I have a current substance abuse problem. Please specify: _____

☐ Yes, I had a past substance abuse problem. Please specify: _____

☐ No, I have never had a substance abuse problem

What is your occupation? _____ Does it involve mostly ☐ standing or ☐ sitting

Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____

Family History

 Is there any family history (blood relative) of: (Please indicate family member)

<input type="checkbox"/> Alzheimer's _____	<input type="checkbox"/> Depression _____
<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Bleeding disorders _____	<input type="checkbox"/> Emphysema _____
<input type="checkbox"/> Blood clot _____	<input type="checkbox"/> Heart disease _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> Cataracts _____	<input type="checkbox"/> Neurological _____
<input type="checkbox"/> Circulation problems _____	<input type="checkbox"/> Strokes _____
<input type="checkbox"/> Other (specify): _____	

Review of Systems

 (Please check the box if you currently have any of these symptoms or check "NONE")

Cardiovascular	<input type="checkbox"/> leg pain when walking	<input type="checkbox"/> fever	<input type="checkbox"/> chest pain/pressure	<input type="checkbox"/> leg swelling	<input type="checkbox"/> cold hands/feet
	<input type="checkbox"/> fainting	<input type="checkbox"/> palpitations	<input type="checkbox"/> vascular disease	<input type="checkbox"/> valve problems	<input type="checkbox"/> NONE
Genitourinary	<input type="checkbox"/> blood in urine	<input type="checkbox"/> hesitancy	<input type="checkbox"/> incontinence	<input type="checkbox"/> increased urgency	
	<input type="checkbox"/> decreased frequency	<input type="checkbox"/> excessive urination	<input type="checkbox"/> kidney disease	<input type="checkbox"/> kidney stones	<input type="checkbox"/> NONE
Gastrointestinal	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> heartburn	<input type="checkbox"/> blood in stool	<input type="checkbox"/> vomiting	<input type="checkbox"/> ulcers
	<input type="checkbox"/> diarrhea	<input type="checkbox"/> trouble swallowing	<input type="checkbox"/> decrease appetite	<input type="checkbox"/> increase appetite	<input type="checkbox"/> constipation
Integumentary	<input type="checkbox"/> athlete's foot	<input type="checkbox"/> nail abnormalities	<input type="checkbox"/> keloids	<input type="checkbox"/> itchiness	<input type="checkbox"/> dry, scaly skin
					<input type="checkbox"/> NONE
Hematologic	<input type="checkbox"/> lower leg ulcers	<input type="checkbox"/> sickle cell disease	<input type="checkbox"/> anemia	<input type="checkbox"/> blood thinners	<input type="checkbox"/> clotting disorders
					<input type="checkbox"/> NONE
Neurological	<input type="checkbox"/> tingling	<input type="checkbox"/> weakness	<input type="checkbox"/> seizures	<input type="checkbox"/> numbness	<input type="checkbox"/> headaches
	<input type="checkbox"/> tremors	<input type="checkbox"/> paralysis			<input type="checkbox"/> NONE
Musculoskeletal	<input type="checkbox"/> back pain	<input type="checkbox"/> joint swelling	<input type="checkbox"/> muscle weakness	<input type="checkbox"/> muscle pain	<input type="checkbox"/> neck pain
	<input type="checkbox"/> sciatica	<input type="checkbox"/> joint stiffness	<input type="checkbox"/> joint pain	<input type="checkbox"/> joint instability	<input type="checkbox"/> arthritis
					<input type="checkbox"/> NONE
Respiratory	<input type="checkbox"/> chest pain	<input type="checkbox"/> wheezing	<input type="checkbox"/> COPD	<input type="checkbox"/> coughing	<input type="checkbox"/> snoring
	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> emphysema			<input type="checkbox"/> NONE

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____

Date: _____

Name: <u>Patient New</u>	Chart #: <u>3377</u>	Date of birth: _____
Race: _____	<input type="checkbox"/> I prefer not to answer	<input type="checkbox"/> I do not know
<i>(White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)</i>		
Ethnicity: _____	<input type="checkbox"/> I prefer not to answer	<input type="checkbox"/> I do not know
Preferred Language: <u>English</u>	<input type="checkbox"/> I prefer not to answer	
Pharmacy Name: _____	Pharmacy Phone: _____	
Pharmacy Address: _____	City, State, Zip: _____	
Primary Care Physician: _____	Phone: _____	Date Last Seen: _____
Address: _____		
Referring Physician: _____	Phone: _____	Date Last Seen: _____
Address: _____		

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐ Yes ☐ No Can we send mail to the address on file? ☐ Yes ☐ No
 Can we call the phone number on file? ☐ Yes ☐ No Can we leave voicemail on machine? ☐ Yes ☐ No
 Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐ Yes ☐ No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Other: _____

Name(s): _____

Smoking Status

☐ Current Every Day Smoker ☐ Never Smoker
☐ Current Some Day Smoker ☐ I decline to answer
☐ Former Smoker

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

☐ No Known Medications ☐ I take the following medications:

Name: _____	Dose: _____
Name: _____	Dose: _____
Name: _____	Dose: _____
Name: _____	Dose: _____
Name: _____	Dose: _____
Name: _____	Dose: _____
Name: _____	Dose: _____
Name: _____	Dose: _____
Name: _____	Dose: _____

Use the back of this form if more room is needed

Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name: _____	Reaction: _____
Name: _____	Reaction: _____
Name: _____	Reaction: _____
Name: _____	Reaction: _____
Name: _____	Reaction: _____
Name: _____	Reaction: _____
Name: _____	Reaction: _____
Name: _____	Reaction: _____
Name: _____	Reaction: _____

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits):* I authorize payment of medical benefits to the practice named above. *(Release of Information):* I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy):* I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History):* I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____

Date: _____

THIS FORM IS TO HELP THE DOCTOR EVALUATE YOUR FOOT PROBLEM
AND PROVIDE NECESSARY INFORMATION FOR FILING INS. CLAIM

Name _____ Date _____
LAST FIRST

Address _____

Phone _____ Date Of Birth _____
HOME OFFICE CELL

Employer _____ Social Security # _____

Name & Address OF Physcian _____

Pharmacy Address & Phone # _____

Do you ever get cramps, tightening of the muscles or burning in feet or legs?
NO _____ YES _____ SOMETIME _____

Do you ever get tingling and/or numbness in your feet?
NO _____ YES _____ SOMETIME _____

After walking a block or two _____ While laying in bed _____ After being on your feet _____

I would like the doctor to take care of (LIST ALL COMPLAINTS)

It has troubled me for : WEEKS _____ MONTHS _____ YEARS _____

Was this problem caused my an injury? If so, how _____

Have you had previous care by a specialist? _____ Are you pregnant? YES _____ NO _____

I Hereby give Dr. M. Montoni permission to examine and treat my feet medically,
surgically, or orthopedically. I have no known herat aliment, diabetes, blood condition
or allergies. (PLEASE WRITE NONE UNLESS ONE OF THESE PROBLEMS EXISTS).

I am presently taking the following medications. _____

SIGNATURE