



**FOOT & ANKLE
SPECIALISTS**
— OF CENTRAL PA —

New Patient Form

First name: _____ **Last Name:** _____

DOB: _____ **Phone Number:** _____

Address:

Insurance:

Primary Insurance:

Secondary Insurance:

Please give all insurance cards to the front desk, so we can scan them into your patient chart

Primary Doctor Information:

Name of Family Doctor _____ City: _____

Date Last Seen: _____

Last A1C: _____

Emergency Contact Information

Emergency Contact Name: _____ Number: _____

HIPAA

I authorize the below person to receive all protected health information/medical records regarding my treatment from Foot and Ankle Specialists of Central PA.

Name: _____ DOB: _____ Number: _____

Medical History

Reason for Visit:

Pain level: 0 1 2 3 4 5 6 7 8 9 10

Previous Treatment:

Have you been diagnosed with any of the following: Please circle

Hypertension (high blood pressure)	Problems with anesthesia
Diabetes	Bleeding Disorder
Hypercholesterolemia (high cholesterol)	Circulatory disorder
Venous Insufficiency	Cancer
Coronary Artery Disease	Blood Clots (DVT)
Atrial Fibrillation (Afib)	Gout
Neuropathy (numbness/tingling)	Non-healing wounds
Charcot Marie Tooth Disease (CMT)	Arthritis
Kidney Disease	Liver Disease

Other: _____

Allergies:

Height: ____ **Weight:** ____ **Shoe Size:** _____

Smoker: Yes No **Previous Smoker:** Yes No **Quit:** _____

Alcohol: Occasionally Socially Rarely

Surgical History: Please circle

Hip Replacement (L or R) Wound Debridement Heart Stents Heart Transplant
Knee Replacement (L or R) Bunion Hammer Toe correction Hysterectomy

Other: _____