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:____

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Allergies:

____

Medications:

____

____

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:__________