FOOT & ANKLE SPECIALISTS
— OF CENTRAL PA —

4 Flowers Drive, Suite 2
Mechanicsburg, PA 17050
(717) 620-8225

PATIENT INFORMATION

Today's Date:

First Name:	**Middle**	**Last:**
Date of Birth:	Age:	Gender: ☐ Female ☐ Male
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Address:		
City:	State:	Zip:
Home Phone:	**Cell Phone:**	
Email Address:		**Preferred Language:**
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	**Race:** ☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ American Indian/Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Other/Decline	

INSURANCE INFORMATION

Insurance Company:	**Subscriber:**		
Policy Number:	Group Number:		
Employer:	Address:		
Phone Number:	City:	State:	Zip:

PATIENT CONTACTS

Family Physician:	**Physician Number:**
Physician Address:	Physician Fax:
Pharmacy:	**Pharmacy Number:**
Pharmacy Address:	
Emergency Contact:	**Emergency Number:**

REFERRAL

How did you hear about Foot and Ankle Specialists of Central PA? (Check all that apply)

☐ Referring Physician _____ ☐ Family/Friend _____

☐ Mailer ☐ Yellow Pages ☐ Google ☐ Facebook ☐ Other: _____

BODY INFORMATION

Height:	**Weight:**
Shoe Size:	**If Diabetic Last A1C:**

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MEDICAL INFORMATION

Reason for visit:
Problem:
Pain Scale (Circle One): 1 2 3 4 5 6 7 8 9 10
Prior Treatment:

PAST MEDICAL HISTORY *(Check all that apply)*

☐ Arthritis	☐ Gastric Reflux	☐ Kidney Disease
☐ Asthma	☐ Gout	☐ Chronic Non-Healing Wounds
☐ Bleeding Disorder	☐ Heart Disease	☐ Neuropathy
☐ Blood Clots (DVT)	☐ Hepatitis	☐ Varicose Veins
☐ Cancer	☐ High Cholesterol	☐ Other _____
☐ Circulatory Disorder	☐ HIV Infection	
☐ Depression	☐ Hypertension (High Blood Pressure)	
☐ Diabetes	☐ Problems with Anesthesia	

PAST SURGICAL HISTORY

1)
2)
3)

FAMILY HISTORY

SOCIAL HISTORY *(Check all that apply)*

☐ Tobacco (pkg/day) _____ ☐ Alcohol ☐ Substance Abuse

MEDICATION ☐ No Medications / ☐ List Attached

ALLERGIES ☐ No Known Allergies

"I certify that the above information is correct to my best knowledge. I understand that I am financially responsible for all charges not paid by my insurance plan. If I am self-pay, I am responsible for full payment on day of service. I understand that co-pays are collected on day of service and cannot be billed. Overdue accounts are assessed late fees and after 90 days, accounts will be sent to collections. I understand that the contact information provided will be used for, but not limited to, appointment and billing reminders, newsletters, new services/announcements and birthday greeting. At any time, I can change my communication preferences."

Signature: _____ Date: _____