All-in-one Foot Care Center

22972 Moulton Pkwy, Suite 105, Laguna Hills, CA 92653
949-588-8833

1 - PATIENT INFORMATION:

First Name

Last Name

Address

City

State

Zip Code

Data of Birth e.g. 01/01/1960

Home Phone e.g. 999-555-1212

Social Security Number e.g. 999-11-9999

Marital Status ○ Married ○ Single ○ Widowed ○ Minor ○ Separated ○ Divorced ○ Partnered

Sex ○ Male ○ Female

Employer/ School

Employer/School Phone e.g. 999-555-1212

In case of emergency contact Name & address

2 - INSURANCE:

Who is the primary on this account? ○ Self ○ Other, Please specify

Data of birth of the primary. e.g. 01/01/1960

Relationship to patient ○ Self ○ Other, Please specify

Insurance Company

Group Number

Subscriber ID

Insurance Phone Number e.g. 999-555-1212

Is patient covered by other insurance?
○ NO (please skip the section below)
○ YES (Please bring information on your secondary insurance)

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with the above insurance company and assign directly to *All-in-One Foot Care Center* all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my acceptance on all insurance submissions.

All-in-One Foot Care Center may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the submission date of this form.

○ I Agree (Beneficiary, Guardian or Personal Representative)

Name

Relationship to beneficiary

3 - PODIATRIC AND MEDICAL HISTORY:

Main reason for visiting us: e.g. foot, ankle, knee, etc.

Have you been to a Podiatrist(s) before ○ No ○ YES - Please list name(s)

Cigarette / Tobacco use ○ No ○ YES - Please specify years smoked

Is there any personal or family history of diabetes? ○ No ○ YES

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	○ YES ○ No	Flat Feet	○ YES, ○ No
Athlete's Foot	○ YES ○ No	Foot or Leg Cramps	○ YES, ○ No
Bunions	○ YES ○ No	Heel Pain	○ YES, ○ No
Corns & Calluses	○ YES ○ No	Ingrown Toenails	○ YES, ○ No
Cramps or Numbness in Feet or Legs	○ YES ○ No	Plantar Warts	○ YES, ○ No

Please choose "YES" or "NO" to indicate if you have had any of the followings:

AIDS/HIV	○ YES ○ No	Hepatitis or Jaundice	○ YES ○ No
Allergies to Anesthetics	○ YES ○ No	High Blood Pressure	○ YES ○ No
Allergies to Medicine or Drugs	○ YES ○ No	Kidney Problems	○ YES ○ No
Anemia	○ YES ○ No	Liver Disease	○ YES ○ No
Angina	○ YES ○ No	Low Blood Pressure	○ YES ○ No
Arthritis	○ YES ○ No	Neuropathy	○ YES ○ No
Artificial Heart Valves or Joints	○ YES ○ No	Phlebitis	○ YES ○ No
Asthma	○ YES ○ No	Psychiatric Care	○ YES ○ No
Back Problems	○ YES ○ No	Radiation Treatment	○ YES ○ No
Bleeding Disorders	○ YES ○ No	Rash	○ YES ○ No
Cancer	○ YES ○ No	Respiratory Disease	○ YES ○ No
Chemical Dependency	○ YES ○ No	Rheumatic Fever	○ YES ○ No
Chest Pain	○ YES ○ No	Shortness of Breath	○ YES ○ No

Chronic Diarrhea	○ YES ○ No	Sinus Problems	○ YES ○ No
Circulatory Problems	○ YES ○ No	Special Diet	○ YES ○ No
Diabetes	○ YES ○ No	Stroke	○ YES ○ No
Ear Problems	○ YES ○ No	Swelling in Ankles, Feet	○ YES ○ No
Epilepsy	○ YES ○ No	Swollen Neck Glands	○ YES ○ No
Eye Problems	○ YES ○ No	Tired Feet	○ YES ○ No
Fainting	○ YES ○ No	Tuberculosis	○ YES ○ No
Gout	○ YES ○ No	Ulcers	○ YES ○ No
Headaches	○ YES ○ No	Varicose Veins	○ YES ○ No
Heart Disease	○ YES ○ No	Venereal Disease	○ YES ○ No
Hemophilia	○ YES ○ No	Weight Loss, Unexplained	○ YES ○ No

Surgeries you have had: _____

Hospitalization other than for the surgeries listed: _____

Family physician Name & last date visited: _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ○ YES ○ NO

If yes, please explain-> _____

Medications? Include prescriptions, OTC medications and vitamins: _____

Pharmacy Name(s): _____ Pharmacy Phone(s): _____

Do you take oral contraceptives ○ YES ○ NO

ALLERGIES

Adhesive/Tape	☐	Local Anesthetics	☐
Anticoagulant Therapy	☐	Novocaine	☐
Aspirin	☐	Penicillin	☐
Codeine	☐	Seafoods	☐
Demerol	☐	Sulfa	☐
Iodine	☐		

Other ☐ Please explain --> _____

TREATMENT CONSENT

☐ I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor seems necessary.

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

PRINT NAME_____

SIGNATURE_____ DATE_____