Rock River Foot & Ankle Clinic, S.C.
PATIENT INFORMATION (please print)

DATE: ____/____/____ SEX: MALE FEMALE

PATIENT FULL NAME: ____ DATE OF BIRTH: ____/____/____ AGE: ______
SOCIAL SECURITY NUMBER: __________________________EMAIL:____
HOME ADDRESS: _______________________________________CITY/STATE: ____________________________ZIP: _________

LANGUAGE: ________________________

RACE: [ ] WHITE [ ] AMERICAN INDIAN OR ALASKA NATIVE [ ] ASIAN [ ] BLACK OR AFRICAN AMERICAN
[ ] NATIVE HAWAIIAN OR OTHER PACIFIC

ETHNICITY: [ ] NON HISPANIC OR LATINO [ ] HISPANIC OR LATINO

MARITAL STATUS: [ ] SINGLE [ ] MARRIED [ ] PARTNERED [ ] SEPARATED [ ] DIVORCED [ ] WIDOWED

PRIMARY CARE DOCTOR: ________________________________ REFERRED BY:_______________________________________
Address: ____

PATIENT'S OR PARENT'S EMPLOYER NAME: ____
ADDRESS: ____
CITY, STATE, ZIP: ____
FULL TIME [ ] **PART TIME [ ]** **RETIRED [ ]**

SPOUSE'S NAME: ______________________________EMPLOYER: ____
ADDRESS: _________________________________CITY, STATE, ZIP: ____
FULL TIME [ ] **PART TIME [ ]** **RETIRED [ ]**

INSURANCE INFORMATION
WHO IS RESPONSIBLE FOR PAYMENT ?

Name:________________________DOB: __________
RELATIONSHIP TO PATIENT:______________________
SS#:____
ADDRESS: ____________________________________
CITY/STATE: ____________________ZIP: ____ ______
PHONE # (____)____-________
Employer: ____________________________________

PRIMARY INSURANCE COMPANY NAME & NUMBERS:
____
INSURED NAME: ________________________________
SUBSCRIBER D.O.B.:______________________________
EMPLOYER_______________________________________

SECONDARY INSURANCE COMPANY NAME & NUMBERS:
__________________________________ ____________
INSURED NAME: ________________________________
SUBSCRIBER D.O.B.:______________________________
EMPLOYER:______________________________________

PHONE NUMBERS

HOME PH#: ____________________________
LEAVE MSG: YES [ ] NO [ ]
WORK PH#: ____________________________
LEAVE MSG: YES [ ] NO [ ]
CELL PH#: _____________________________
LEAVE MSG: YES [ ] NO [ ]

Preferred phone number: ________________

IN CASE OF EMERGENCY CONTACT:

NAME: ____
RELATIONSHIP: _________________________________
PHONE #: _____________________________________

IS THIS A WORKER'S COMPENSATION CLAIM?

[ ] YES [ ] NO

IF YES, PLEASE COMPLETE ADDITIONAL WORKER'S COMPENSATION FORM

Name:___________________

MEDICAL INFORMATION

This information is important for our records and your health.

Describe your foot problem: ____
Which foot: ____________ How Long: _______________ Any Injury: ___________________

Shoe size: __________ Width: N M W Current Height: __________ Weight:__________

What medications are you allergic to: ____
Any other allergies: (Metal or jewelry) ______________________ Adhesive Tape?____________
Have you had problems taking Aspirin, Ibuprofen, Tylenol, Advil, Motrin, etc.? Yes______ No_____
Any problem with local anesthetics (Novocaine, Lidocaine)? Yes______ No _______
For females only – Are you pregnant? Yes_____ No_____ Have you had a hysterectomy? Yes____ No____

GENERAL HEALTH INFORMATION

Do you have Diabetes? Yes _____No _____ Using Insulin? Yes _____ No _____ No. of years Diabetic_____
Are you taking Coumadin (Blood Thinners)? Yes_______ No_______
Please list any serious illnesses: ____
Please list any surgeries: ____
Please list any foot surgeries: ____
Please list any surgical complications: ____
Are you under a physician's care? Yes_____ No______ If yes, for what condition(s): ____________________
____

List all medications you take: ____
____
____

Pharmacy name and phone number: _________________________ ____________________

Please check ☐ any of the following you have, or have had a problem with:

☐ Heart	☐ Circulation	☐ Cancer	☐ Skin
☐ Kidneys	☐ Arthritis	☐ Asthma	☐ Tuberculosis
☐ Lungs	☐ Anemia	☐ Stomach Ulcers	☐ Unexplained Weight Loss
☐ Liver	☐ Frequent Infections	☐ High Blood Pressure	☐ Neurological Disorder
☐ Intestines	☐ Healing	☐ Gout	☐ Depression/Mental Disorder
☐ Hepatitis	☐ Rheumatic Fever	☐ Elevated Cholesterol	☐ Other _________________

Do you have any artificial joints? Yes_____ No_____ Which one?______________________________
Do you have a Heart Valve Implant? Yes_____ No_____ Do you have a Pacemaker? Yes______ No______

Family History: Please list any known medical problems for the relatives listed below:
For example: diabetes, breast/colon/ovarian/prostate cancer, heart disease, stroke, arthritis, bleeding disorder, neurological disorder, bunions, flat feet, etc.

Mother: ____
Father: ____
Brothers: ____
Sisters: ____
Children: ____
Other: ____

Do you smoke? Yes_____ # packs per day_____
No_____
Previously smoked? Yes_____ # of years______
No_____

Do you drink alcohol or beer? Yes____________
No_____
☐ 1-2 per week ☐ 1-2 per day ☐ More than 2 daily