Fremont Foot and Ankle

NEW PATIENT INFORMATION

Name (Last)_____(First)_____(MI)_____
Home Address _____ Apt. #_____
City _____ State _____ Zip _____
Phone # (Home) _____ (Cell) _____
Email (for medical portal access) _____
SS#_____ Age ___ Date of Birth _____/_____/_____ Gender: M / F
Employer _____ Phone # _____
Emergency contact Name: _____
Phone #: _____ Relationship: _____
How did you hear about us? _____
Primary Care Physician (PCP): _____
Date last seen PCP: _____

Ethnicity Please circle one: (American Indian) (Asian) (Black/African American)
(Pacific Islander) (White) (Hispanic) (Declined to answer)

IMPORTANT POLICIES AND CONSENT

-If applicable, may we leave medical information on your home answering machine, voicemail or with a family member? (ex: appointment reminders, lab results, insurance coverage info., etc.?)
NO _____ YES _____ If NO, please write the number we should use: _____

-I understand that I must call 24 hr. prior to appointment to cancel or reschedule or I will be responsible for a $35 fee. I also understand that I am responsible for the unpaid amount not covered by my insurance. Any billing questions please call our office. Payment plans or assistance can be arranged. Insurance requires us to collect your copay which will be paid prior to being seen.

-I certify that the above information is true and correct to the best of my knowledge. I give my permission to the Dr. Morgan Kizzar, DPM to administer and perform such treatment/procedures as may be deemed necessary in the diagnosis and/or treatment of my feet, ankles or lower legs. I hereby authorize medical information to be sent to my primary physician.

Insurance Authorization

I release any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree to acknowledge that my signature on this authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents.

SIGNATURE _____DATE _____
Relationship to patient if a minor: _____

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MEDICAL HISTORY FORM:

Name_____DOB_____
Primary care doctor name _____
Primary care doctor phone number _____
Date last seen by your primary doctor _____
Prefered pharmacy _____
Other specialists seen (cardiology, endocrinology, nephrology)
Specialty: _____ Name: _____ Phone: _____
Specialty: _____ Name: _____ Phone: _____
Specialty: _____ Name: _____ Phone: _____

Are you under a pain management contract? (YES/NO)
Pain management clinic name _____

Are you Diabetic (YES/NO)
Last Eye Exam Date _____ Eye Doctor's Name _____
Last Hemoglobin A1C _____ Date _____

ALLERGIES: (YES/NO) A= true allergies S= sensitivity
Environmental:
Adhesive tape/Latex _____ Shellfish _____ Iodine _____
Medication:
Aspirin _____ Codeine _____ Penicillin _____ Sulfa _____
Tetracyclines _____ Local Anesthetics _____ Other _____

FLU Shot (YES/NO)
Height _____ Weight _____

MEDICAL DIAGNOSIS: (Number of years)

AIDS/HIV _____	Gout_____	Liver Disease _____
AFIB_____	Hepatitis _____	Stroke _____
Asthma_____	Heart Disease_____	Stomach Ulcers _____
Anemia_____	High Blood	Thyroid Disease _____
Diabetes_____	Pressure _____	Tuberculosis_____
Epilepsy_____	High Cholesterol _____	Varicose Veins_____
GERD___	Kidney Disease_____	Other _____

SOCIAL HISTORY: (Please circle)

Nicotine use (Past/Current/Never) Drug use (YES/NO)
Alcohol use (Daily/Weekly/Monthly) Marijuana (YES/NO)

SURGICAL HISTORY: (attach a list) _____

_____

_____

Medication List and Dose: (attach a list) _____

_____

_____

_____

_____

Have you experienced...

Back problems: (YES/NO)
Episodes of fainting: (YES/NO)
Headaches: (YES/NO)
Shortness of breath: (YES/NO)
Tingling/numbness in toes: (YES/NO)
Foot/Leg cramps: (YES/NO)
Itchy skin on feet: (YES/NO)
Swelling of feet/ ankles: (YES/NO)
Dryness of skin: (YES/NO)
Foot/Leg cramps while walking: (YES/NO)
Excessive scarring (Keloid): (YES/NO)

Main (foot/ankle/leg) issue and reason for today's visit? _____

_____

_____

How long has it been bothering you? _____
If applicable, what was the date of injury? _____
X-Rays taken for injury/issue (YES/NO) Where _____ When _____
Previous treatment if any? _____