HAYS
FOOT & ANKLE CENTER

Patient Information:

First Name:______________________________ Last Name:_________________________________ M.I.________

SS#______________________ Age:__________ Date of Birth:______________ Gender: M F

Marital Status: Married Single Domestic Partner Divorced Separate Widowed Minor

Address:____ Apt. #:____________

City:_________________________________ State:__________ Zip Code:______________________________

Contact Information: Home ( )______________ Cell: ( )_______________ Business: ( )________________

Preferred Contact: Home Cell Business May we leave detailed messages at that number:_______________

Email:___________________________ Employer Name:_________________ Occupation:____________________

Emergency Contact:___________________ Relation:_______________ Phone #:( )______________________

Primary Care Physician:______________________________ Physician Phone #: ( )______________________

If you are a minor or under the supervision of a legal guardian, please complete the following information:

Responsible Party for Account:__________________________Relationship to Patient:________________________

Address:_____________________________ City:_______________ State:________ Zip Code:_________________

Contact Information: Home ( )______________ Cell ( )______________ Business ( )_________________

Insurance Information:

Primary Insurance Name:____________________________ Plan Type: PPO HMO Other:_______________

Policy #:__________________________ Group #:_______________________ Effective Date:_________________

Insurance Phone Number: ( )________________ Insured Name:_____________ Employer:________________

Secondary Insurance Name:__________________________ Plan Type: PPO HMO Other:_______________

Policy #:__________________________ Group #:_______________________ Effective Date:_________________

Insurance Phone Number: ( )________________ Insured Name:_____________ Employer:________________

How did you hear about Hays Foot and Ankle Center?

____

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HAYS
FOOT & ANKLE CENTER

Patient Name: ____________________ Date: ____________

Medical Information

Shoe Size: ________ Height: ________ Weight: ________

Podiatric History:
What is your Primary concern today?

____

____

How long has the problem been present?

____

____

What causes the problem or makes it "worse"?

____

____

Any other Foot/Ankle problems that need attention? ______________________________

____

Plese list previous injuries to the foot or ankle. ______________________________

____

Surgical History: *use back if necessary*

Surgery	Date

Medications: *please list*

Name	Dosage

Medical History:
Do you currently have or ever been treated for:
circle all that apply

- Alzheimers
- Anemia
- Arthritis
- Asthma
- Bleeding Disorder
- Blood in Urine
- Bronchitis
- Cancer
- Depression
- Diabetes
- Eczema
- Emphysema
- Epilepsy
- Forgetfulness
- Glaucoma
- Gallbladder
- Gout
- Headaches
- Hearing Problems
- Heart Attack
- Hepatitis
- High Blood Pressure
- Kidney Disease
- Leg Pain Walking
- Liver Disease
- Lung Disease
- Nerve Disorders
- Osteoporosis
- Prostate
- Sciatica
- Seizures
- Stomach Problems
- Stroke
- Thyroid
- Tuberculosis
- Varicose Veins
- Other: ______________

____

Are you pregnant: ☐ Yes ☐ No
Delivery Date: ______________________________

Do you use: Tobacco Alcohol Illicit Drugs
Frequency of use: ______________________________

Family History:
circle all that apply

- Arthritis
- Cancer
- Diabetes
- Epilepsy
- Heart
- Hypertension
- Kidney
- Tuberculosis
- Other: ________

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Allergies: *please list*

Drug	Reaction