# TABLE MOUNTAIN FOOT & ANKLE CLINIC, P.C.

**Patient Name:**___________________________________________ **Age:**_________ **Today's Date:**________________
First M.I. Last

**Address:**_____________________________________________________________________________________
Street Unit City State Zip

**Home# (____) _________________ Work # (____) _________________ Cell # (____) __________________________**

**Birth Date:**_________________ **Sex: M F Height:** _________ **Weight:** ___________ **Marital Status: S M D W**

**S.S. #** _______-______-_________ **Primary Physician:** __________________________ **Phone: (_____)**____________

**Emergency Contact Name:** ______________________________________ **Phone: (______)** __________________

**Whom may we thank for recommending our clinic to you?** ______________________________________________

**Medications? Please list:**

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

**Allergies to any medications, materials or foods?**______________________________________________________

**Have you had, or do you have any of the following? ( check all that apply )**

___ AIDS/HIV
___ ANEMIA
___ ARTHRITIS
___ ASTHMA
___ BLEEDING TENDENCY
___ CANCER YR. DIAG. _____
___ CIRCULATORY PROBLEMS
___ CONVULSIONS
___ DIABETES YR. DIAG. _____
___ OTHER __________________________________________

___ EYESIGHT IMPAIRMENT
___ GOUT
___ HEPATITIS ____
___ HIGH BLOOD PRESSURE
___ HEART PROBLEMS
___ KIDNEY PROBLEMS
___ KNEE PAIN
___ LEG CRAMPS
___ LOW BACK PAIN

___ LOW BLOOD PRESSURE
___ M.S.
___ NEUROPATHY
___ PHLEBITIS
___ CURRENT PREGNANCY
___ RHEUMATIC FEVER
___ RESPIRATORY PROBLEMS
___ SHORTNESS OF BREATH
___ STINTS
___ STOMACH PROBLEMS

**Previous Surgeries:**__________________________________________________________________________

**Please discribe the nature of your foot problem:** _____________________________________________________
___________________________________________________________________________________________

**Was this an injury? Y N Date of Injury**__________________ **Auto Work Other** ____________________________

**Occupation** ________________________________________ **Employer** _____________________________________

**Do you smoke?** _______ **Packs per day?** _______ **Do you drink alcohol?** ___________ **Coffee?** _______

**Primary Insurance**__________________________ **Secondary Insurance** _____________________________________

**Insured's Name**______________________________ **Insured's S.S.#** ___________- _________- __________________

**Insured's D.O.B.** ___________________________________

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Assignment: I hearby authorize my insurance benefits be paid directly to the physician and acknowledge that I am financially resposible for any unpaid balance.

PATIENT SIGNATURE: ______________________________________________

Date: _______________

RELEASE: I authorize the physician to release any information required to my insurance company.

PATIENT SIGNATURE: ______________________________________________

Date: _______________

## MEDICARE PATIENTS:

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE TO MY DOCTOR FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENGS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

___________________________________________

PRINT NAME OF BENEFICIARY (PATIENT )

___________________________________________

SIGNATURE OF BENEFICIARY

WORKS COMP. CLAIM # ___________________________________________

CONTACT NAME & # ___________________________________________