WOLF RIVER FAMILY FOOTCARE, PLLC
7424 HWY 64, STE. 119, BARTLETT, TN 38133
PH 901-381-2800 FAX 901-381-2677

PATIENT INFORMATION

PATIENT LAST NAME FIRST MIDDLE GENDER

DATE OF BIRTH AGE SOCIAL SECURITY NUMBER HOME PHONE

ADDRESS CITY/STATE/ZIP MARITAL STATUS M S D W

EMPLOYER WORK PHONE CELL PHONE

RESPONSIBLE PARTY/GUARDIAN DATE OF BIRTH EMPLOYER

ADDRESS CITY STATE ZIP PHONE

EMERGENCY CONTACT NAME (RELATIONSHIP TO PATIENT) PHONE

PLEASE LIST WITH WHOM WE MAY DISCUSS YOUR MEDICAL CONDITION AND/OR FINANCES

*MAY WE LEAVE VOICEMAIL OR MESSAGES VIA PHONE FOR YOU? YES NO

PRIMARY CARE PHYSICIAN_____PHONE_____

DATE OF LAST APPOINTMENT_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	SECONDARY INSURANCE COMPANY
POLICY NUMBER	POLICY NUMBER
GROUP NUMBER	GROUP NUMBER
SUBSCRIBER NAME	SUBSCRIBER NAME
DATE OF BIRTH	DATE OF BIRTH

I the undersigned certify that I (or my dependent) have insurance with the above listed insurance company, and assign directly to Wolf River Family Footcare, PLLC, 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 hereby authorize Wolf River Family Footcare, PLLC, to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. In Medicare assigned cases, Wolf River Family Footcare, PLLC, agrees to accept the charge determination of the Medicare carrier as the full charge, and I will only be responsible for non-covered services, deductibles, and co-insurance, which are based upon the charge determination of the Medicare carrier.

SIGNATURE OF SUBSCRIBER/RESPONSIBLE PARTY DATE

MEDICAL HISTORY

PLEASE INDICATE BY CIRCLING IF YOU NOW HAVE OR HAVE HAD ANY OF THE FOLLOWING:

AIDS/HIV ANEMIA ARTHRITIS ARTIFICIAL HEART VALVES OR JOINTS ASTHMA GOUT BACK PROBLEMS BLEEDING DISORDERS CHEMICAL DEPENDENCY CANCER CHEST PAIN CIRCULATORY PROBLEMS DIABETES EPILEPSY HEART DISEASE HEPATITIS LIVER DISEASE HIGH BLOOD PRESSURE KIDNEY PROBLEMS PSYCHIATRIC PROBLEMS PHLEBITIS STROKE SHORTNESS OF BREATH RESPIRATORY PROBLEMS ULCERS OTHER_____

PLEASE LIST ANY SURGERIES OR HOSPITALIZATIONS YOU HAVE HAD:

_____

DO YOU HAVE A FAMILY HISTORY OF DIABETES, HEART DISEASE, CANCER, OR OTHER? (CIRCLE ONE)

DO YOU SMOKE? _____HOW MANY PACKS PER DAY?_____FOR HOW MANY YEARS?_____

HAVE YOU EVER SMOKED?_____FOR HOW LONG, AND WHEN DID YOU QUIT?_____

DO YOU DRINK ALCOHOL?_____

ARE YOU ALLERGIC TO: PENICILLIN SULFA CODEINE DEMORAL IODINE ASPIRIN ANESTHETICS ANTI COAGULANTS ADHESIVE TAPE OTHER_____

PLEASE LIST CURRENT MEDICATIONS, INCLUDING VITAMINS, HERBS, AND OVER THE COUNTER MEDICATIONS:_____

_____

_____

PHARMACY ADDRESS PHONE

PODIATRIC HISTORY

HAVE YOU EVER BEEN TO A PODIATRIST?_____FOR WHAT COMPLAINT?_____

PODIATRIST NAME_____DATE OF LAST APPT_____

INDICATE WHICH FOOT OR ANKLE PROBLEMS YOU HAVE NOW :

PAIN SWELLING ITCHING BUNIONS CORNS CALLUSES NUMBNESS BURNING CRAMPS HEEL PAIN WARTS NEUROMAS FLAT FEET BLISTERS INGROWN TOENAILS OTHER_____

HAVE YOU RECEIVED ANY TREATMENT FOR THESE PROBLEMS IN THE PAST?_____

CONSENT

I certify that the above information is true and correct to the best of my knowledge, and I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and treatment of my feet and/or ankles.

_____

SIGNATURE DATE