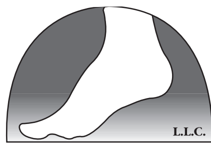


ACCT. NO. ______________

CASCADE FOOT CLINIC

PODIATRIC PHYSICIANS & SURGEONS

AMBROSE K. SU, D.P.M.
Board Certified

WELCOME TO OUR OFFICE

To aid in delivering the best possible health care, please complete in full

PATIENT PERSONAL INFORMATION

Name: First Middle Last		Soc. Sec. No.:	Family Doctor:
Mailing Address:		Date last seen by Family Doctor	Pharmacy
City	State / Zip	Next appt.	
Home: Phone ( )	Birth Date: / / Age:	Sex M / F	Marital Status *(Circle One)* Single Married Separated Divorced Widowed
Work:	Emergency Contact:	Employer/ School:	Occupation
Cell:		Is this an on-the-job injury? Yes ☐ No ☐	

☛ If this is an on-the-job injury, please notify the receptionist before continuing.

Date and time of injury________________________________

Workers Comp insurance______________________________

INSURANCE *Please present your insurance forms, cards and identification to the receptionist*

As a courtesy, this office will bill your primary insurance. A rebilling fee will be charged for all outstanding balances.

Primary Insurance Name:		Secondary Insurance Name:	
Insured Name on I.D. Card:	Insured's Birth Date: / /	Insured Name on I.D. Card:	Insured's Birth Date: / /
Soc. Sec. No. Member Policy ID		Soc. Sec. No. Member Policy ID.	
Patient relationship to insured: ☐Self ☐Spouse ☐Child ☐Other____________________		Patient relationship to insured: ☐ Self ☐Spouse ☐ Child ☐ Other ___________________	

REFERRAL SOURCE *Please tell us how you chose us to provide your podiatric care*

I was referred by___________________________, a ☐ Current or Past Patient ☐ Doctor ☐Nurse or the ☐ ___________Hospital

I saw your name/ad in: ☐ Insurance Co. Provider List ☐ Yellow Pages ☐ Brochure/Literature ☐ Sign ☐ Just passing by

☐The _________________ Newspaper or Magazine ☐ Dr.'s Lecture ☐ Other

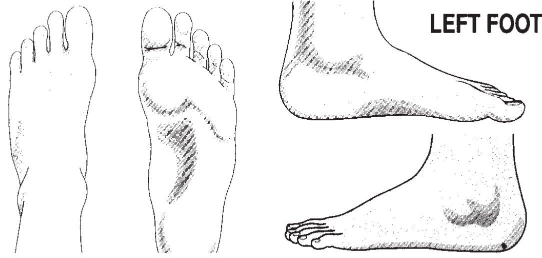
ACCOUNT TERMS AND PAYMENTS *For Non-Insurance covered items and services*

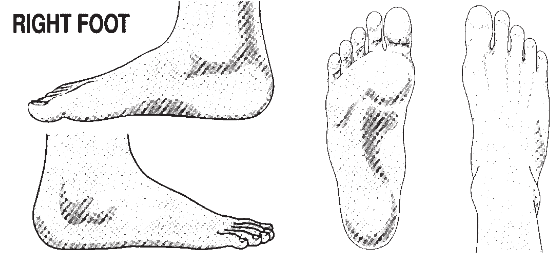
When your account has balances due over 60 days: Your MONTHLY COST OF REBILLING/ACCOUNT MAINTENANCE CHARGE is $3.00	Today I will pay my bill by ☐Cash ☐VISA ☐Check In the Future, I can pay my bill by: ☐ Cash ☐ VISA ☐ Check

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician. I am financially responsible for non-covered charges. I also authorize the physician to release any information required.

Patient or Authorized Person's Signature ______________________________ **Date** ______________

PATIENT'S CURRENT MEDICAL PROBLEMS





Please mark the location of your foot complaint.

Please describe your foot complaint below

____

____

____

____

Does it limit your physical activities/work? ☐ Yes ☐ No

If yes, describe ________________________________

Has it caused you to wear different shoes? ☐ Yes ☐ No

If yes, describe ________________________________

Pain/Discomfort is

☐ Shooting Pain
☐ Throbbing Pain
☐ Sharp Pain
☐ Burning Pain
☐ Itching
☐ Aching Pain
☐ Tenderness
☐ Dull Pain
☐ Tingling
☐ Numbness

My pain/discomfort began (when)__________

____

It occurs when ________________________

____

Intensity is

☐ Mild
☐ Moderate
☐ Severe

It is getting

☐ Better
☐ No Change
☐ Worse

Describe any previous medical treatment(s) or home remedies:

____

____

PATIENT MEDICAL HISTORY:

HEIGHT______ WEIGHT______ SHOE SIZE______

What percentage of your hours awake are you on your feet?

(Circle one) 20% 40% 60% 80% 100%

List any sports/regular exercise you are active in:

____

____

Do your feet hurt at night?	☐ Yes	☐ No
Do you have any difficulty in walking?	☐ Yes	☐ No
Do you get leg cramps?	☐ Yes	☐ No
Any pain in calves or buttocks when walking?	☐ Yes	☐ No
Is the pain relieved by rest?	☐ Yes	☐ No
Do you have vascular grafts?	☐ Yes	☐ No
Do you have joint implants?	☐ Yes	☐ No
Do you have replacement heart valves?	☐ Yes	☐ No
Are you now under active chemotherapy?	☐ Yes	☐ No
Do you take any blood thinners?	☐ Yes	☐ No
Do you have poor circulation?	☐ Yes	☐ No
Do you have feet or leg numbness?	☐ Yes	☐ No
Are you slow to heal after cuts?	☐ Yes	☐ No
Are you currently pregnant?	☐ Yes	☐ No
Any abnormal bruising or bleeding?	☐ Yes	☐ No

Do you have or have you ever been treated for:

☐ Epilepsy	☐ Nerve disorder	☐ Cancer
☐ Depression	☐ Stomach Ulcer	☐ Psychiatric disorder
☐ Glaucoma	☐ Rheumatic Fever	☐ Scarlet Fever
☐ Stroke	☐ Heart Attack	☐ High Blood Pressure
☐ Trauma	☐ Phlebitis	☐ Heart Disease
☐ Diabetes	☐ Hepatitis	☐ Liver Disease
☐ Anemia	☐ Gout	☐ Kidney Disease
☐ Asthma	☐ Lung Disease	☐ Thyroid Disease
☐ Angina	☐ Arthritis	☐ None of these

Have you had any other serious illness? ☐ Yes ☐ No

Please list any previous surgeries/date

________________________ ________

________________________ ________

________________________ ________

________________________ ________

Are you taking insulin? ☐ Yes ☐ No

Are you currently taking any medications? ☐ Yes ☐ No

Please list medications or, if available, please present your list of medications or medical illness to the receptionist:

__________ __________ __________

__________ __________ __________

__________ __________ __________

Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:

(Check box that applies)	**Yes**	**No**	**Don't Know**
Penicillin or other antibiotics	☐	☐	☐
Morphine, Codeine, Demerol or other natcotic...	☐	☐	☐
Novocaine or other anesthetics	☐	☐	☐
Aspirin, Empirin or other pain remedies	☐	☐	☐
Metals..	☐	☐	☐
Adhesive tape..	☐	☐	☐
Any other drug, medication or treatment	☐	☐	☐

If yes, list: ________________________________

List relationship to you of family members who have had:

Diabetes________________ Foot Problems ________________

Arthritis________________ Heart Attack ________________

Stroke________________ High Blood Pressure ________________

Cancer ________________ Birth Defects ________________

Do you smoke now? ☐ No ☐ Yes Packs/day___ Years___

Did you ever smoke? ☐ No ☐ Yes Packs/day___ Years___

If you quit, when did you do so? ________________________

Alcoholic beverages? *(Circle one)* None Rarely Moderately Daily Quit

Recreational Drugs? *(Circle one)* None Rarely Moderately Daily Quit