The Center for Foot Care

WELCOME TO OUR OFFICE: Complete the following information for your case history file. (Please Print)

Patient's Name (Last) (First) (M.I.)			Sex: ☐ Male ☐ Female	Today's Date
Social Security Number	Date of Birth	Age	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Home Address	City	State	Zip	
Home Phone	Cell Phone	Business Phone		
Email Address	Name of Employer	Occupation		
Spouses Name / Guardian (if under 18)		Date of Birth		
Name of Contact in Case of Emergency	Phone Number	Relationship		

Primary Medical Insurance	Name of Insured	Date of Birth
Secondary Medical Insurance	Name of Insured	Date of Birth
Family Physician	Phone Number	Date Last Seen

Family History: ☐ Diabetes ☐ Hypertension ☐ Seizures ☐ Bleeding Disorders ☐ Foot Problems ☐ Cancer ☐ Gastric Ulcers ☐ Gout ☐ Other	Patient's Pharmacy / Phone
Social History: Tobacco: Y / N Alcohol: Y / N How Much? Caffeine: Y / N Illicit Drug Use: Y / N	How Did You Hear About Our Office?
Describe Your Chief Foot/Ankle Complaint:	Have You Been Treated For This Before? Y / N What Was Done? What Doctor?
Past Patient Surgeries and Hospitalizations / Date	
Patient Medication/Doses	Patient Allergies

I hereby give **Dr. Kristin Titko** permission to administer treatment and perform such procedures as may be necessary for the diagnosis and treatment of my foot and/or ankle condition. Also, I hereby authorize the release of the any medical information necessary to process my claim. I also authorize payment to the above mentioned doctor from insurance company(ies) for services rendered to me. My permission is given to the above mentioned doctor to keep my other medical care providers informed of my medical information, progress, and treatment obtained. I understand that as a courtesy Podiatry of Hamilton, Inc. dba Center for Foot Care will file all insurance claims for me and I am ultimately responsible for payment of all services rendered.

Signature of Patient or Legal Gudian of Minor / Date _____