Batavia Foot Care Center
Podiatric Medicine & Surgery

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Batavia, NY 14020
(585) 344-1677
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www.bataviafootcarecenter.com
info@bataviafootcarecenter.com

PATIENT INFORMATION:

____
(Last Name) (First Name) (MI) (Maiden)

Address ____ City __________________ State ______ Zip Code ___________

Home # (____) ___________________ Mobile # (____) ___________________ Work # (____) _____________________

Email _______________________________ Gender ☐ Male ☐ Female Gender Identity _______________________

Birth Date ____/_____/_____ Age _____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partnered

Primary Care Physician _________________________________ Spouse's Name __________________________________

Height ____________ Weight ____________ Shoe Size ____________ Pharmacy ____________________________

EMPLOYMENT INFORMATION:

Employer ____ Job Title ________________________________
Employment Status ☐ Full-time ☐ Part-time ☐ Retired ☐ Self-employed ☐ Disabled (reason) ______________________

CONTACTS:

Who can we leave a message with or discuss your medical condition including diagnosis, treatment and payment with?
Name _____________________________________ Relationship _________________ Phone # (____) ________________

Do we have permission to communicate information regarding medications and/or appointments by:
Home Answering Machine ☐ Yes ☐ No With Another Person ☐ Yes ☐ No Work Answering Machine ☐ Yes ☐ No
Send Via E-mail/Portal ☐ Yes ☐ No Cell Phone Voice Mail ☐ Yes ☐ No Mobile Text ☐ Yes ☐ No

Preferred method to receive patient billing statements: ☐ Text message ☐ e-mail ☐ Paper statement
Appointment reminder preference: ☐ Text message ☐ e-mail ☐ Phone call

INSURANCE INFORMATION:

Primary Insurance ____ Policy ID _____________________________________

Subscriber Name ____________________________________ Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber Sex ☐ Male ☐ Female Date of Birth ____/_____/_______

Secondary Insurance ____ Policy ID: __________________________________

Subscriber Name ____________________________________ Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber Sex ☐ Male ☐ Female Date of Birth ____/_____/_______

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ Physician ____________________________________ ☐ Google ☐ Internet Search ☐ Insurance Website ☐ Facebook
☐ Instagram ☐LinkedIn ☐ Telephone Book ☐ Family/Friend ____
☐ Other ____

REASON FOR VISIT:

What is the reason for your visit today? ____
How long has it bothered you? ____________________ What is your level of pain? (scale of 1 to 10) ____ / 10
The pain quality is: ☐ Burning ☐ Constant ☐ Dull ☐ Sharp ☐ Shooting ☐ Throbbing ☐ Tingling ☐ Other ________________
What treatments have you tried? ____
Is this pain/problem a result of an injury? ☐ Yes ☐ No Describe ____
Is this pain/problem work related? ☐ Yes ☐ No Describe ____
Former Podiatrist(s) ____ Last Visit Date ____/_____/_____

MEDICAL HISTORY:

Are you Diabetic? ☐ Yes ☐ No Last A1C: _________ Who manages your diabetes? _________________________
Date last seen by Primary Care Physician or Endocrinologist for diabetes management: ____/_____/_____

Please check any of the conditions that currently apply **OR** that you have experienced in the past:
☐ Auto-immune issues (ex. Rheumatoid arthritis, etc.): specify ____
☐ Bleeding/Clotting Issues: specify ____
☐ Breathing Issues: specify ____
☐ Cancer: specify ____
☐ Diabetes: (Type I or Type II) Year diagnosed ________________
☐ Heart Issues: specify ____
☐ High Blood Pressure ☐ High Cholesterol/lipids
☐ Kidney issues: specify ____
☐ Liver issues: specify ____
☐ Musculoskeletal issues (ex. Arthritis, Gout, Scoliosis, Stenosis, Factures, etc): _________________________________
____
☐ Neurologic issues (ex. Neuropathy, Sciatica, Migraines): specify ____
____
☐ Psychologic issues: specify ____
☐ Stomach issues (ex. GERD, IBD, Ulcers, etc.): specify ____
☐ Vascular/Venous issues (ex. Peripheral vascular disease, venous insufficiency, varicose veins): specify _______________
____

SURGICAL HISTORY: Have you had any of the following surgeries?

☐ **NONE** ☐ Appendectomy ☐ Female surgery ☐ Cataract Surgery ☐ Ear tubes ☐ Gallbladder ☐ Hernia
☐ Musculoskeletal/Foot ☐ Tonsils/Adenoids ☐ Vascular/Heart Surgery ☐ Wisdom Teeth ☐ Bone/Joint
☐ Other: ____
Please specify details of above: ____

Have you had any surgeries on your foot/ankle? ☐ Yes ☐ No
Please list foot/ankle surgeries: ____
Do you have any artificial joints? ☐ Yes ☐ No Where? ____

FAMILY HISTORY: Is there a family history of? (Check box for relationship and circle D if family member is **deceased**)

	Mother	Father	Brother	Sister		Mother	Father	Brother	Sister
High Blood Pressure	☐ D	☐ D	☐ D	☐ D	Cancer	☐ D	☐ D	☐ D	☐ D
Bleeding Disorders	☐ D	☐ D	☐ D	☐ D	Blood Clot	☐ D	☐ D	☐ D	☐ D
Circulation Problems	☐ D	☐ D	☐ D	☐ D	Diabetes	☐ D	☐ D	☐ D	☐ D
Heart Disease	☐ D	☐ D	☐ D	☐ D	Stroke	☐ D	☐ D	☐ D	☐ D

SOCIAL HISTORY:

Have you had two or more falls within the last 12 months? ☐ Yes ☐ No
Are you currently pregnant? ☐ Yes ☐ No If yes, how many weeks: ________ Are you currently nursing? ☐ Yes ☐ No
Alcohol use: ☐ Never ☐ No Longer Use ☐ Current ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily
Tobacco use: ☐ Never ☐ Quit How long ago? _______ Current Use: ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily
Tobacco type: ☐ Cigarettes ☐ Smokeless tobacco ☐ Pipe ☐ Cigar ☐ Vape
Illicit/Recreational Drug use: ☐ Past history of ☐ Current
Exercise: ☐ Never ☐ Rare ☐ Occasional ☐ Weekly ☐ Several times a week ☐ Daily
Hobbies: ____
Sports: ____

MEDICATIONS: (Please list below or provide a separate sheet)

Medication	Dose	Frequency	Medication	Dose	Frequency

ALLERGIES: Please mark any allergies you may have. List any allergies not shown. ☐ **NO KNOWN ALLERGIES**

☐ Adhesive Tape Reaction: ____________________
☐ Aspirin Reaction: ____________________
☐ Codeine Reaction: ____________________
☐ Iodine Reaction: ____________________
☐ NSAIDS Reaction: ____________________
☐ Sulfa Reaction: ____________________
☐ Anesthetics Reaction: ____________________
☐ Betadine Reaction: ____________________
☐ Cortisone Reaction: ____________________
☐ Latex Reaction: ____________________
☐ Penicillin Reaction: ____________________
☐ Silver Reaction: ____________________
☐ Other: ____

ADVANCED DIRECTIVES:

Do you have advanced directives? ☐ Yes ☐ No Do you have a living will? ☐ Yes ☐ No
Do you have a Durable Power of Attorney? ☐ Yes ☐ No If so, POA Name: ______________________________

TREATMENT AND INSURANCE CONSENT:

I hereby consent and give my permission to Batavia Foot Care Center, its healthcare providers, assistants and/or designated replacement to administer and perform such procedures and treatments upon me as they deem necessary. I give consent for Batavia Foot Care Center to bill my insurance and collect payment for rendered services.

____ DATE ____/_____/_____
(Signature of Patient, Guardian or Representative)

Name of Representative (if applicable) ______________________________________ Relationship: _______________