Batavia Foot Care Center
Podiatric Medicine & Surgery

3922 West Main Street Road
Batavia, NY 14020
(585) 344-1677
FAX: (585) 344-2105
www.bataviafootcarecenter.com

PATIENT INFORMATION:

_____
(Last Name) (First Name) (MI)

Address _____ City _____ State _____ Zip Code _____

Phone# (____) _____ Mobile # (____) _____ Work # (____) _____

Email _____ Gender ☐ Male ☐ Female Pharmacy _____

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

Primary Care Physician _____ Phone# (____) _____ Last Visit Date ____/_____/_____

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 statements:
☐ Text message ☐ e-mail ☐ Paper statement

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 ☐ Insurance Website ☐ Facebook ☐ 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 What happened? _____
Is this pain/problem work related? ☐ Yes ☐ No What happened? _____
Former Podiatrist(s) _____ Last Visit Date ____/_____/_____

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
Use of alcohol: ☐ Never ☐ No Longer Use ☐ Current ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily
Use of tobacco: ☐ Never ☐ Quit How long ago? _____ Current Use: ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily
Exercise: ☐ Never ☐ Rare ☐ Occasional ☐ Weekly ☐ Several times a week ☐ Daily

ALLERGIES: Please mark any allergies you may have. List any allergies not shown. ☐ No Known Allergies

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

☐ Other: _____

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

_____	Dose/Frequency: _____
_____	Dose/Frequency: _____
_____	Dose/Frequency: _____
_____	Dose/Frequency: _____
_____	Dose/Frequency: _____
_____	Dose/Frequency: _____
_____	Dose/Frequency: _____
_____	Dose/Frequency: _____

SURGICAL HISTORY: Have you had any of the following surgeries?
☐ None ☐ Appendectomy ☐ C-Section/female surgery ☐ Cataract Surgery ☐ Ear tubes ☐ Female ☐ Gallbladder
☐ Hernia ☐ Musculoskeletal/Foot ☐ Tonsils/Adnoids ☐ Vascular/Heart Surgery ☐ Wisdom Teeth
☐ 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? (Circle relationship)

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

MEDICAL HISTORY:

Are you Diabetic? ☐ Yes ☐ No Last A1C: _____ Who manages your diabetes? _____
Have you received a flu vaccine? ☐ Yes ☐ No Date of injection ____/_____/_____
Have you received a pneumonia vaccine? Date of injection ____/_____/_____

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 _____
_____

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: _____
Do you have a Surrogate Decision Maker? ☐ Yes ☐ No If so, Surrogate 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: _____