FOOTCARE, P.A.

ARE YOU NOW OR HAVE YOU BEEN UNDER A PHYSICIAN'S CARE IN THE PAST TWO YEARS? **YES** **NO**

IF YES, PLEASE EXPLAIN:

_____

_____

_____

LIST PRESENT MEDICATIONS:

_____

PREFERRED PHARMACY: _____ PHONE NO. (_____)_____

ARE YOU DIABETIC? **YES** **NO**

IS THERE A FAMILY HISTORY OF DIABETES? **YES** **NO**
IF YES, LIST RELATIONSHIP_____

LIST ALLERGIES TO DRUGS/MEDICATIONS (ex: penicillin, Novocaine, adhesive tape):

_____

HEIGHT: _____ WEIGHT:_____

SHOE SIZE:_____ WIDTH: **NARROW** **REGULAR** **WIDE**

FAMILY PHYSICIAN:_____DATE LAST SEEN:_____

FORMER PODIATRIST:_____DATE LAST SEEN:_____
WHAT CONDITION WERE YOU TREATED FOR?

_____

WHAT IS THE NATURE OF YOUR PRESENT FOOT PROBLEM?

_____

_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

I hereby give **FootCare, P.A.**, permission to evaluate, diagnose, treat and manage my podiatric condition. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance to your prior consent. This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.
4. I have the right to request that the use of my Protected Health Information that is used or disclosed for the purposes of treatment, payment, or health care operations be restricted. **FootCare, P.A.** is not bound by the restriction unless it is in agreement with the restriction.

Signature of Patient or Guardian: _____**Date:** _____