

Advanced Podiatry Demographic & Primary Complaint Form

It is a requirement of the federal government that this information be collected on each new patient and updated yearly for existing patients. Thank you for your cooperation, Dr. Cupp and Staff.

Name _____ Age _____ DOB _____
First Middle Last

Address _____ City _____ State _____ ZIP _____

Primary Phone _____ Other Phone _____ Social Sec _____ Sex F M

Marital Status S M W D Sep Patient's Employer/School _____ Phone _____

Primary Language _____ Ethnicity: Not Hispanic or Latino Hispanic or Latino
Race: White Native American Asian Black/African American Native Hawaiian/other Pacific Islander Other

Spouse/Parent/Legal Representative Information:

Name _____ Phone _____

Address _____ Employer _____

Emergency Contact Name _____ Phone _____

Insurance Information:

Primary _____ Policy Number _____ Group _____

Secondary _____ Policy Number _____ Group _____

Tertiary _____ Policy Number _____ Group _____

Benefits to Physician & Release of Information

YES NO

I hereby authorize payment directly to the physician of the surgical and/or medical benefits. I understand my insurance policy is a contract between me and my insurance company. I accept financial responsibility for payment of all deductible, co-insurance, and other balances not paid by my insurance company. The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV & AIDS.

What is your primary foot complaint today? _____

When did this start? ___ days ___ weeks ___ months ___ years Is the problem getting better/worse/unchanged?

Was this a result of trauma? Yes No

Does this affect your walking? Yes No

Does this affect your ability to exercise? Yes No

Does this affect your daily activity? Yes No

Was this a job-related injury? Yes No If yes, when did injury occur? _____

How would you describe your pain? (circle all that apply)

generalized localized throbbing radiating burning numbness dull ache sharp ache other

Rate the severity of your pain: 1 2 3 4 5 6 7 8 9 10 (severe)

What treatments have you tried for this problem? _____

Do you have any other foot problems? _____

I hereby give my permission to Nicole Cupp, DPM, to administer treatment and to perform such minor operative procedures as may be deemed necessary in the diagnosis, and/or treatment of my foot condition. I understand all of the above and hereby state that the information is correct to the best of my knowledge.

→Signature: _____ Date: _____