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 _____

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: _____