Advanced Podiatry Demographic & Primary Complaint Form

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

Name_____ Age_____ DOB_____
First Middle Last

Address_____ City_____ State_____Zip_____

Home Phone_____ Cell 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_____ Address_____ Phone_____

Insurance Information:
Primary_____ Policy Number_____ Group Number_____

Secondary_____ Policy Number_____ Group Number_____

Tertiary_____ Policy Number_____ Group Number_____

*IF THE PRIMARY POLICY HOLDER IS SOMEONE OTHER THAN YOURSELF, PLEASE PROVIDE THE FOLLOWING:
Policyholder Name: _____ Policy Holder DOB_____

Policy Holder Social Sec._____

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 any 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. 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:**_____

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
Dos 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?_____