Timothy M. Fisher, DPM

Family Foot Care

313 W. Drake Road
Fort Collins, CO 80526
Phone: (970) 225-5027
Fax: (970) 797-7296

PATIENT INFORMATION

FULL NAME _____ **TODAY'S DATE** _____

BIRTHDATE _____ **EMAIL**_____ □ **MALE** □ **FEMALE**

STREET ADDRESS _____ **CITY** _____ **STATE**_____

ZIP_____ **CELL PHONE** _____ **HOME PHONE** _____

SCHOOL OR PLACE OF WORK _____

WORK PHONE _____ □ **FULL-TIME** □ **PART-TIME** □ **RETIRED**

EMERGENCY CONTACT _____ **PHONE** _____

PREFERRED PHARMACY _____

Will you be using: INSURANCE _____ **or** **SELF PAY**

RELEASE OF INFORMATION: I authorize Advanced Foot Care to release medical information to my insurance company and authorize insurance payment to Timothy M. Fisher, DPM. I understand I am financially responsible for all charges not covered by my insurance and that payment for services not covered is required at the time of service.

PATIENT SIGNATURE _____ **DATE** _____

SUBSCRIBER'S INSURANCE INFORMATION (ONLY IF DIFFERENT FROM PATIENT)

SUBSCRIBER'S FULL NAME_____ □ ***Spouse*** □ ***Parent/Guardian***

STREET ADDRESS _____***CITY*** _____***STATE*** _____ ***ZIP***_____

PHONE _____ ***SUBSCRIBER'S BIRTHDATE*** _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the notice of privacy practices and that I have read (or had the opportunity to read if I so chose) and understand the notice.

PATIENT SIGNATURE_____ **DATE**_____

I will allow access to my medical records by: □ Spouse □ Parent(s) □ Child(ren) □ Other □ None

Name_____

Who referred you to us? □Friend/family □Online □Insurance □Doctor □Other_____

Referral Name/Details: _____

What is your main reason for visiting today? _____

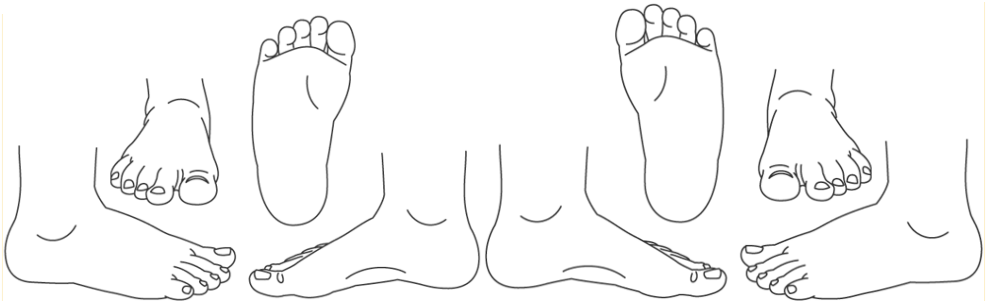
_____

Do you have any other foot/ankle problems? _____

_____

Mark the problem area(s) on the diagrams below:

Right Foot **Left Foot**



When did your main problem begin? _____

Is your concern due to an injury? _____

Have you fallen in the last 6 months? _____

I'm having: □Burning □Throbbing □Sharp □Dull □Tingling □Numbness □Itching □Swelling □Redness □No pain □Constant □Intermittent □Other____

Have you already seen any healthcare provider for this issue(s) before today? YES NO

Treatments used:

□Medications □Icing □Soaking □Stretching □Inserts/orthotics □Shoe Changes □Prior procedure □Surgery

□(Ankle) bracing □Splinting □Toe spacers/sleeves □Injections (cortisone) □Resting □Liquid Nitrogen

□Other_______

Treatment Details: _____

What helps? _____

What makes it worse? _____

Do you wear shoes in your home? _____

Do you wear compression socks/stockings?_____

Your Primary Care Provider_____

Past Surgeries (any)_____

_____

HEIGHT: **WEIGHT:** **AGE:** **SHOE SIZE:**

Your current medications/prescriptions:

MEDICATION	DOSE	MEDICATION	DOSE	MEDICATION	DOSE

Are you allergic to any medications/food?

□ NO KNOWN ALLERGIES
□ PENICILLIN
□ SULFA
□ TETRACYCLINE
□ CEPHALOSPORINS
□ ERYTHROMYCIN
□ ASPIRIN / NSAIDS
□ CODEINE
□ DEMEROL
□ IODINE/BETADINE
□ TAPE
□ FOODS _____
□ OTHER _____
_____

Your Medical History:

□ ALCOHOLISM
□ ARTHRITIS
□ ANEMIA
□ ANXIETY
□ ASTHMA
□ BACK PAIN
□ BLEEDING DISORDERS
□ BLOOD CLOTS (DVT)
□ CANCER_____
□ COPD
□ DEMENTIA
□ DEPRESSION
□ DIABETES (Type I or Type II)
□ DRUG ADDICTION
□ EPILEPSY
□ FIBROMYALGIA
□ FOOT ULCERS
□ GANGLION CYSTS
□ GOUT
□ HEART DISEASE
□ HEPATITIS
□ HIGH BLOOD PRESSURE
□ HISTORY OF FALLING
□ HIV
□ JOINT REPLACEMENT
□ KIDNEY DISEASE
□ KNEE PAIN
□ MENTAL ILLNESS
□ MULTIPLE SCLEROSIS
□ OSTEOPOROSIS/OSTEOPENIA
□ OSTEOARTHRITIS
□ PHLEBITIS
□ PERIPHERAL NEUROPATHY
□ RAYNAUD'S DISEASE
□ RESTLESS LEG SYNDROME
□ RHEUMATIC FEVER
□ RHEUMATOID ARTHRITIS
□ STOMACH ULCERS
□ STROKE
□ THYROID DISORDER
□ OTHER _____
_____

Do you use tobacco? YES NO
If YES, what type and how much daily? _____

How long has it been since you quit tobacco? _____

About how much alcohol do you drink weekly? _____

Do you use any other substances? YES NO

Please sign authorization to treat:

I authorize Dr. Timothy M. Fisher to perform examination, evaluate, and treat my foot/ankle problems.

SIGNATURE _____ DATE _____