

Last Name: _____ First Name: _____ MI: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home # (____) Cell # (____) Work # (____)
 Emergency Contact: _____ Phone: (____) Relationship: _____
 E-Mail: _____

Family Physician: _____ Phone Number: (____)
 Fax Number: (____)

Birth Date: ____ / ____ / ____ Marital Status: Single Married Widowed Divorced

Employer: _____ Employer Address: _____

____ FULL TIME ____ PART TIME ____ NOT EMPLOYED ____ SELF-EMPLOYED ____ RETIRED ____ ACTIVE MILITARY DUTY ____ STUDENT

Pharmacy: _____ Pharmacy Phone Number: (____)

HOW DID YOU HEAR ABOUT US: Doctor Referral Insurance Friend/Family Internet/Google
 Referred by: _____ Other: _____

RELEASE OF PERSONAL INFORMATION TO THE PATIENT'S DESIGNEES

I authorized medical staff members of this practice to discuss my medical history, diagnosis, treatment and prognosis with other medical providers and organizations that participate in care and with those listed below.

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits and services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____, hereby authorize _____ to pay and hereby assign directly to MARIN FOOT AND ANKLE CENTER all benefits. I further acknowledge that any insurance benefits, when received by and paid to MARIN FOOT AND ANKLE CENTER will be credited to my account in accordance with the above said assignment.

Agreed & Authorized: _____ **Date:** _____

SOCIAL HISTORY

Do or Did you smoke cigarettes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, packs per day?	_____ Stop date: _____
Drink alcohol regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you exercise regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to any medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, which medications?	_____
Place of Birth?	_____	Unusual Occupational Exposures?	_____
Please list ALL medications you are currently taking:			

MEDICAL HISTORY:

Previous Surgery/Hospitalizations _____

Blood Transfusions (dates): _____ General Anesthesia: _____

Injuries and Fractures (types & dates): _____

FAMILY HISTORY (check if anyone in your family has had or had the following)

	MOTHER	FATHER	SIBLINGS	CHILDREN	OTHER RELATIVE
CANCER					
DIABETES					
HEART DISEASE					
ARTHRITIS					
OSTEOPOROSIS					
AGE (IF LIVING)					

SYSTEMIC REVIEW (DO YOU NOW HAVE OR EVER HAD THE FOLLOWING)

	YES	NO		YES	NO
Chronic Headaches/Migraines			Diabetes		
Dizziness			High Blood Pressure		
Fainting Spells/Blackouts			High Cholesterol		
Eye Disease/Glaucoma/Cataracts			Joint Pains/Swelling		
Double Vision			Swelling of _____ Feet _____ Ankles		
Recent Vision Impairment			Numbness/Tingling of hand/Feet		
Impaired Hearing			Color Changes in the Hands		
Ringing in the Ears			Chest Pressure/Chest Pain		
Dryness of _____ Eyes _____ Mouth			Chronic Back Pain		
Recent Hair Loss			Chronic Neck Pain		
Asthma			Parkinsonism		
Recurrent Fever			Osteoporosis		
Thyroid Disorder			Sciatica		
Pneumonia			Anemia or Blood Disorder		
Pleurisy			Skin Rash		
Frequent Cough			Psoriasis		
Tuberculosis Exposure			Recent Weight _____ Gain _____ Loss		
Difficulty Breathing			Loss of Appetite		
Coughing Up Blood			Constant Thirst or Hunger		
Rheumatic Fever			Stomach/Duodenal Ulcer		
Difficulty Urinating			Abdominal Pain/Heart Burn		
Painful/frequent Urination			Frequent Nausea/Vomiting		
Blood in Urine			Heart Murmur		
Nighttime Urination _____ Times			Cancer		
Prostate Disorder			Palpitations		
Recurring Bladder Infections			Convulsions OR Epilepsy		
Kidney Disease/Stones			Hepatitis/Jaundice		
Pancreatitis			HIV Virus Positive		
Diverticulitis			Chronic Anxiety		
Phlebitis			Depression		
Insomnia					

Date of: Most Recent Medical Exam _____

EKG _____ Blood Tests _____ Chest X-Ray _____

Reason for office visit today: _____