Charlotte Foot & Ankle Specialists
2550 W. Arrowood Road, Suite 102
Charlotte, NC 28273
704-504-4000

Patient Information: *PLEASE COMPLETE BOTH SIDES OF THIS FORM.*

Last Name: _____ Home Phone: _____

First Name: _____ Cell Phone: _____

Address: _____ Work Phone: _____

Apt or Unit #:_____ City: _____ State: _____

Zip Code: _____ Email Address:_____

Gender: M / F Marital Status: M D S W SO DOB: ____/____/_____ Age: _____

Employer: _____ Job Title: _____

Social Security #:_____-_____-_____ Driver's License #:_____

Other Information

Primary Care Physician: _____

Address: _____Phone:_____

Pharmacy Name: _____Phone:_____

Street Address: _____State:_____

Emergency Contact Name: _____

Phone: _____ Relationship:_____

How did you hear about us? Internet / Phone Book / Friend / Family Member / Insurance Website/ Doctor

What is the reason for your visit today? _____

How long has it bothered you? _____

Treatments tried: _____

Did the treatments help? _____

Medical History

Medical Conditions: *Circle all that applies.*

Arthritis	Hepatitis	Heart Conditions
Bleeding Disorders	High Blood Pressure	Gout
Cancer	High Cholesterol	Stroke
Diabetes	HIV / AIDs	Hyper/Hypothyroidism
Fibromyalgia	Neurological Disorders	Other:_____
Fungal Infections	Neuropathy	

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Medications: *Please list **medication/dose/frequency** here or provide a complete list.*

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Allergies: *Circle all that apply.*

Latex/Tape Lidocaine Penicillin

Shellfish / Iodine Sulfa Other:_____

Surgeries: *Please specify **Right** or **Left***

_____

_____

_____

Other Health Information: Required by Government

Height: _____ Weight: _____ Shoe Size: _____ Do You Smoke: **Y / N / Former**

How Many Packs Daily: _____ How Long: _____ **Women**: Are you/could you be **pregnant**?:_____

Have you had a flu vaccine this year? _____ Have you had a pneumonia vaccine?_____

Family History: *Check all that apply to each family member.*

	Mother	Father	Brother	Sister	Son	Daughter	Other
Living or Deceased?	**L / D**	**L / D**	**L / D**	**L / D**	**L / D**	**L / D**	
High Blood Pressure	_____	_____	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____	_____	_____
Bleeding Disorders	_____	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____	_____
Fibromyalgia	_____	_____	_____	_____	_____	_____	_____
Hepatitis	_____	_____	_____	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____	_____	_____	_____
HIV/AIDS	_____	_____	_____	_____	_____	_____	_____
Neuropathy	_____	_____	_____	_____	_____	_____	_____
Heart Conditions	_____	_____	_____	_____	_____	_____	_____
Gout	_____	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____	_____

Other:_____

_____

_____

Payment Policy: As a courtesy, we will bill your insurance company for services rendered. However, you are responsible for any co pay, deductible, or coinsurance at the time of your visit. If you insurance does not make payment on your behalf, it will be your responsibility to make sure that the services you received are paid for. We accept: Cash, Checks, Money Orders, Visa, MasterCard, and Discover.