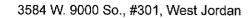
Francis J. Clark, DPM Clay B Shumway, DPM





PATIENT INFORMATION:

Patient Name: (First)	(Initial)	(Last)		
Mailing Address:	City		State	Zip
Phone:()CellPhone()		Text Y or N Da	ate of Birth	//Age
Sex: Male Female E-mail Address Height: Weight: Marital Status: Sir	ngle / Married	/ Divorced / Wid	low / Stude	nt
Language: English / Spanish / Other Race: American Indian or Alaska Native / Asian / Bl Islander / White / Hispanic / Other Ethnicity: Hispanic or Latino / Non-Hispanic or Latino	ack or Africa	ın American / N	ative Hawa	aiian or other Pacific
Patient's Employer:	Busines	s Phone:		
Spouse/Parent:Sp	pouse/Parent	: Phone Number:		
Emergency Contact Person:				
Emergency Contact Person: Name (someone not living with you) Referred By: Doctor / Hospital / Insurance Plan / Family	addı Friend / Int /	tess ternet / Other		phone
Primary Care Physician:				
First Pharmacy	Last	Phone#		phone
Pharmacy(Name and address)		1 11011677		
Are you being seen as a result of an accident? Yes: Date of Accident:// Claim #	No: If	yes, the followin	ig information	on is required:
PERSON RESPONSIBLE FOR BILL: (if other than pati Parent or Guardian who presents with child for treatment	ent, i.e. parei nt will be resp	nt/spouse/guardi oonsible for all ch	narges incui	rred.
Primary Insurance	Ina Na			y Insurance
ns. Name Policy #	IIIS. INE	mie		
	Subso	#	·	
Subscriber NameSubscriber's Date of Birth//	Subsci	riber Name riber's Date of Ri	rth /	
Subscriber's relationship to Patient	Subsci	riber's relationsh	p to Patien	t
hereby give Francis J. Clark, DPM and Clay B Shumway and associng the event that my insurance carrier is billed for service rendered, I B Shumway and, or other treating doctor(s).	iates permission authorize paym	to examine and trea ent of medical benefi	t my lower lim ts directly to F	bs. rancis J. Clark, DPM, Cla
authorize release of any medical information necessary to process t	he claim.			
authorize Francis J. Clark, DPM and Clay B. Shumway and associal	tes to view my p	rescription history fro	m outside res	ources (pharmacy).
AUTHORIZATION FOR ASSIGNMENT OF BENEFITS TO F	OOT & ANKLI	E INSTITUTE OF U	JTAH, LLC	
x				1 1 .
Patient/Guardian Signature				Date

PATIENT HISTORY

ALLERGIES to Medications?: Y or N	(If ye	es	Please circle those YOU have/are treated for:
please list below with reaction)			HEADT: Phaymatic Foyor Murmur Chart Pain
			HEART: Rheumatic Fever, Murmur, Chest Pain,
			Heart Attack, Angina, Congestive Heart Failure,
			Hypotension, Hypertension, Heart Disease,
			Phlebitis, Vascular Disease, Poor Circulation
Has anyone in your family (Mother, fath	er, sib	inas.	CIVINIA Abnounced housing a comment a city - NA-L-
grandparents(Specify Maternal or Paterna			SKIN: Abnormal bruising/scarring, Lesions, Moles,
uncle, etc.) had any of the following? It			Eczema, Rashes, Cancer, Slow to heal
Anthoritie (amanifus)			·
Deep Vein Thrombosis (DVT)			ENDOCRINE: Diabetes-Type I, Diabetes-Type II,
One and (what this 40)		**	Gout, Hypoglycemia, Thyroid Dysfunctions (low or
Cancer (what kind?)			high), Lyme's Disease
Diabetes			
Gout			GASTROINTESTINAL: Stomach Ulcers, Hiatal
Heart Attack			Hernia, Acid Reflux, Diverticulitis, Diarrhea, IBS
High Blood Pressure			, , , , , , , , , , , , , , , , , , , ,
Osteoporosis			BLOOD: Anemia, Bleeding Tendencies, Deep Vein
Stroke			Thrombosis (DVT), Pulmonary Embolism.
Do you drink alcohol?	Yes	No	Other,
If yes, how much?			LIVED, Handitia Liver Ducturation, Call Bladden
Do you smoke?	Yes	No	<u>LIVER</u> : Hepatitis, Liver Dysfunction, Gall Bladder Disease.
If Yes, Packs per Day# of year			Disease.
If Yes, are you interested in stopping	Yes	No	
Are you a former smoker?	Yes	No	MUSCULO-SKELETAL: Serious injuries, Back
			Problems, Deformities, Loss of Strength, Joint Pain,
Do you chew tobacco?	Yes	No	Osteoarthritis, Osteoporosis, Rheumatoid Arthritis,
Do you use recreational drugs?	Yes	No	Lupus, Cramps, Fibromyalgia, Muscular Dystrophy,
If Female, ARE YOU PREGNANT?	Yes	No	Multiple Sclerosis
Please list all surgeries you have hat the approximate dates:			<u>NEUROLOGIC</u> : Alzheimer's, Anxiety, Depression, Epilepsy, Weakness, Numbness, Stroke, Seizures, Migraines, Nervous Condition, Sciatica
			<u>LUNGS</u> : Asthma, Lung Disease, Pneumonia,
			Shortness of Breath, Emphysema, Pulmonary
			Embolism, Tuberculosis
			KIDNEYS: Kidney Disease, Bladder problems,
Are you currently taking any medicatio	ns?	ΥN	
Are you taking Insulin?		ΥN	Prostate problems, Kidney stones
,			OTHER:
Please list current medications and	streng	ths	OTTILIT.
you are presently taking: (INCLUDE).	ALL		What is your foot/ankle problem?
VITAMINS AND OVER THE COUNTER	R MED	S)	what is your lookarikle problem:
			Date of Onset:
		· · · · · · · · · · · · · · · · · · ·	What previous treatment? Surgery / Orthotics / Oral
		 .	
			Medications / Cortisone Shots /
			Other
			Describe any accident or event
List the sport/type of dance you are active in:			When was the first visit to a doctor for this problem?
			
I have answered all questions to the bes	t of my	knowledg	e. Should further information be needed, you have my
permission to ask the respective health notify the doctor of any changes in my h			agency, who may release such information to you. I will on.
X			,
Patient/Guardian Signature	······································	**	Date .