Francis J. Clark, DPM
Clay B Shumway, DPM

3584 W. 9000 So., #301, West Jordan

PATIENT INFORMATION:

Patient Name: (First) _____(Initial)_____(Last)_____

Mailing Address:_____City_____State_____ Zip_____

Phone:(____)_____CellPhone(____)_____Text Y or N Date of Birth___/___/___Age____

Sex: Male__ Female__ E-mail Address_____
Height: _____Weight:_____ Marital Status: Single / Married / Divorced / Widow / Student

Language: English / Spanish / Other _____
Race: American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or other Pacific Islander / White / Hispanic / Other _____
Ethnicity: Hispanic or Latino / Non-Hispanic or Latino

Patient's Employer: _____ Business Phone: _____

Spouse/Parent: _____ Spouse/Parent Phone Number: _____

Emergency Contact Person:_____
Name (someone not living with you) address phone
Referred By: Doctor / Hospital / Insurance Plan / Family / Friend / Internet / Other_____

Primary Care Physician:_____
First Last phone
Pharmacy_____Phone#_____
(Name and address)
Are you being seen as a result of an accident? Yes: ___ No: ___ If yes, the following information is required:
Date of Accident: ___/___/___ Claim # _____ Case Worker_____ Phone:_____

PERSON RESPONSIBLE FOR BILL: (if other than patient, i.e. parent/spouse/guardian) Note to Divorce Parents: Parent or Guardian who presents with child for treatment will be responsible for all charges incurred.

Primary Insurance	Secondary Insurance
Ins. Name_____	Ins. Name_____
Policy #_____	Policy #_____
Subscriber Name_____	Subscriber Name_____
Subscriber's Date of Birth_____/_____/_____	Subscriber's Date of Birth_____/_____/_____
Subscriber's relationship to Patient_____	Subscriber's relationship to Patient_____

I hereby give Francis J. Clark, DPM and Clay B Shumway and associates permission to examine and treat my lower limbs.
In the event that my insurance carrier is billed for service rendered, I authorize payment of medical benefits directly to Francis J. Clark, DPM, Clay B Shumway and, or other treating doctor(s).

I authorize release of any medical information necessary to process the claim.

I authorize Francis J. Clark, DPM and Clay B. Shumway and associates to view my prescription history from outside resources (pharmacy).

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS TO FOOT & ANKLE INSTITUTE OF UTAH, LLC

X_____ /___/_____.
Patient/Guardian Signature Date

Please Turn Over

PATIENT HISTORY

ALLERGIES to Medications?: Y or N (If yes please list below with reaction)

_____

_____

_____

Has anyone in your family (Mother, father, siblings, grandparents(Specify Maternal or Paternal), aunt, uncle, etc.) had any of the following? If so, who?.

Arthritis (specify)_____
Deep Vein Thrombosis (DVT)_____
Cancer (what kind?)_____
Diabetes_____
Gout_____
Heart Attack_____
High Blood Pressure_____
Osteoporosis_____
Stroke_____

Do you drink alcohol?	Yes	No
If yes, how much?_____		
Do you smoke?	Yes	No
If Yes, Packs per Day _____ # of years_____		
If Yes, are you interested in stopping	Yes	No
Are you a former smoker?	Yes	No
Do you chew tobacco?	Yes	No
Do you use recreational drugs?	Yes	No
If Female, ARE YOU PREGNANT?	Yes	No

Please list all surgeries you have had along with the approximate dates:

_____
_____
_____
_____
_____

Are you currently taking any **medications**? Y N
Are you taking **Insulin**? Y N

Please list current medications and strengths you are presently taking: (*INCLUDE ALL VITAMINS AND OVER THE COUNTER MEDS)*

_____
_____
_____
_____
_____
_____
_____

List the sport/type of dance you are active in:

_____
_____

Please circle those YOU have/are treated for:

HEART: Rheumatic Fever, Murmur, Chest Pain, Heart Attack, Angina, Congestive Heart Failure, Hypotension, Hypertension, Heart Disease, Phlebitis, Vascular Disease, Poor Circulation

SKIN: Abnormal bruising/scarring, Lesions, Moles, Eczema, Rashes, Cancer, Slow to heal

ENDOCRINE: Diabetes- Type I, Diabetes-Type II, Gout, Hypoglycemia, Thyroid Dysfunctions (low or high), Lyme's Disease

GASTROINTESTINAL: Stomach Ulcers, Hiatal Hernia, Acid Reflux, Diverticulitis, Diarrhea, IBS

BLOOD: Anemia, Bleeding Tendencies, Deep Vein Thrombosis (DVT), Pulmonary Embolism.
Other,_____

LIVER: Hepatitis, Liver Dysfunction, Gall Bladder Disease.

MUSCULO-SKELETAL: Serious injuries, Back Problems, Deformities, Loss of Strength, Joint Pain, Osteoarthritis, Osteoporosis, Rheumatoid Arthritis, Lupus, Cramps, Fibromyalgia, Muscular Dystrophy, Multiple Sclerosis

NEUROLOGIC: Alzheimer's, Anxiety, Depression, Epilepsy, Weakness, Numbness, Stroke, Seizures, Migraines, Nervous Condition, Sciatica

LUNGS: Asthma, Lung Disease, Pneumonia, Shortness of Breath, Emphysema, Pulmonary Embolism, Tuberculosis

KIDNEYS: Kidney Disease, Bladder problems, Prostate problems, Kidney stones

OTHER:_____

What is your foot/ankle problem?_____
_____
_____

Date of Onset:_____

What previous treatment? Surgery / Orthotics / Oral Medications / Cortisone Shots /
Other_____
Describe any accident or event_____

_____

When was the first visit to a doctor for this problem?
_____

I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

X_____ / / .
Patient/Guardian Signature Date