WISCONSIN FOOT CENTER, LLC
step forward
11035 W Forest Home Avenue Suite 120
Hales Corners, WI 53130
414-425-8400

PATIENT INFORMATION FORM

PLEASE PRINT

DATE: _____ **PATIENT'S NAME:** _____

NICKNAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____ ☐**MALE** ☐**FEMALE**

PARENT OR GUARDIAN (IF A MINOR): _____

ADDRESS: _____ **APT:** _____ **CITY**_____

STATE: _____ **ZIP:** _____ **EMAIL:** _____

HOME PHONE: _____ **WORK PHONE:** _____ **CELL PHONE:**_____

S.S.#: _____ **EMPLOYER:** _____

PRIMARY LANGUAGE: _____ **RACE:** _____ **ETHNICITY:**_____

EMERGENCY CONTACT: _____ **PHONE:** _____

RELATIONSHIP:_____

MEDICAL HISTORY

REASON FOR SEEING DOCTOR TODAY:_____

PREVIOUS FOOT, ANKLE, OR LEG PROBLEM: _____

DO YOU WEAR ORTHOTICS IN YOUR SHOES? _____

LIST ANY OTHER OPERATIONS & DATES: _____

HEIGHT: ____**FT** _____**INCHES** **WEIGHT:** _____**LBS** **SHOE SIZE:** _____

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

□ HEART TROUBLE	□ STOMACH ULCERS	□ HARDENING OF THE ARTERIES
□ KIDNEY TROUBLE	□ BONE FRACTURES	□ RAYNAUD'S DISEASE
□ HIGH BLOOD PRESSURE	□ ASTHMA	□ VARICOSE VEINS
□ POLIO	□ ANEMIA	□ ARTHRITIS
□ RHEUMATIC FEVER	□ BLOOD DISEASE	□ CANCER
□ TUBERCULOSIS	□ CIRCULATION DISEASE	□ SEIZURE DISORDER/EPILEPSY
□ STOMACH ULCERS	□ LIVER TROUBLE	□ DIABETES
□ PROLONGED BLEEDING	□ STROKE/TIA	

OTHER: _____

FAMILY PHYSICIAN/PHONE: _____

PHARMACY/PHONE: _____

REFERRED BY: _____

FORMER PODIATRIST: _____

CURRENT MEDICATIONS: _____

ALLERGIES: □ NONE

□PENICILLIN □CODEINE □CORTISONE □ANESTHETICS □ASPIRIN □VICODIN □IODINE

□ OTHER: _____

DO YOU SMOKE? □ NEVER □ NO □YES _____PACKS/DAY HOW MANY YEARS? _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

INSURED: _____ **INSURED DATE OF BIRTH:** _____

POLICY NUMBER: _____ **GROUP NUMBER:** _____

SECONDARY INSURANCE COMPANY: _____

INSURED: _____ **INSURED DATE OF BIRTH** _____

POLICY NUMBER: _____ **GROUP NUMBER:** _____

Permission to treat: I hereby authorize Dr. Andrew J. Marso to perform such general procedures as he may deam necessary in the diagnosis and/or treatment of my foot condition. I further authorize the release of medical information for insurance purposes and request that payment of benefits be made directly to the doctor. I understand that any remaining balance will be my responsibility.

Authorization to release information: I authorize Dr. Andrew J. Marso, DPM to release any information regarding the medical history and treatment including disability related information to any third party payer (including Medicare), or their contracted agents, to validate or determine benefits payable for services rendered to myself or any dependents.

SIGNATURE (PATIENT OR GUARDIAN): _____**DATE:** _____

Acknowledgement of receipt of notice of privacy practices: I acknowledge that I have read (or had the opportunity to read it if I so choose) and understood the privacy notice. I understand that a paper copy will be provided to me if I request one.

SIGNATURE (PATIENT OR GUARDIAN): _____**DATE:** _____