WISCONSIN FOOT CENTER, LLC
step forward
6130 S. 108th Street
Hales Corners, WI 53130
414-425-8400

PATIENT INFORMATION FORM

(**PLEASE PRINT**)

Date: _____ **Patient Name:** _____

Date of Birth: _____ **Age:** _____ ☐ **Male** ☐ **Female** **Marital status:** ☐ **married** ☐ **divorced** ☐ **single**

Parent or guardian (If a minor): _____

Address: _____**City**_____ **State** _____ **Zip** _____

Email: _____

Primary Phone #: _____ **Work #** _____ **Cell Phone #:** _____

S.S. #: _____ - _____ - _____ **Employer:** _____

Primary Language: _____**Race:** _____ **Ethnicity: Hispanic Non-Hispanic Asian**

Emergency contact: _____ Relationship: _____ Phone#_____

INSURANCE INFORMATION

Primary Insurance Company: _____

Insured Name: _____ Insured D.O.B.: _____Relationship to insured_____

Policy #: _____Group # _____

Secondary Insurance Company: _____

Insured Name: _____ Insured D.O.B. _____Relationship to insured_____

Policy #: _____ Group # _____

CONSENTS

☐ **Permission to treat** I authorize Dr. Andrew J. Marso to perform such general procedures as he may deem 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.

☐ **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.

☐ **Acknowledgement of receipt of notice of Office Policy:** Payment is due at the time services are rendered. A 3.95% processing fee applies to debit and credit card payment transactions. The 3.95% fee is waived when paying by ACH, cash or check.

☐ **Permission to E-mail/Text**: I give Wisconsin Foot Center and staff permission to correspond with me via email/ text for purpose of appointment confirmation, changes to appointment, informational e-mails and conveying general information. I understand that e-mail is not a secure form of communication, and that confidentiality of any e-mail information cannot be ensured. Our office may forward e-mails internally to those involved, as necessary, for healthcare operations and other handling. Our staff will not forward e-mails to independent third parties without patients' prior written consent, except as authorized or required by law. **Please be advised that e-mail is not to be used to communicate urgent matters or emergencies. Responses to e-mails will be given within 1-2 business days, excluding holidays.**

►►**Patient or guardian Signature:** _____**DATE:** _____

MEDICAL HISTORY

Reason for your visit today: _____

Previous foot, ankle, or leg problem: _____

_____

Do you wear an insert or device in your shoe? □ **No** □ **Yes (**Be s**pecific):** _____

List any foot or ankle surgery: _____**Year**_____

Height: _____ **feet** _____**inches** **Weight:** _____**Lbs.** **Shoe size:** _____ Width_____

Have you been treated for any of the following? (Please circle)

Arthritis	**Diabetes**	**Anemia**	**Raynaud's disease**
Kidney Disease	**Prolonged Bleeding**	**Circulatory /Vascular Disease**	**Varicose Veins**
High Blood Pressure	**Foot Fracture**	**Liver Disease**	**Rheumatoid Arthritis**
Stomach ulcer	**Asthma**	**Depression/Anxiety**	**Cancer** _____
HIV/AIDS	**Hepatitis A B C**	**Difficulty Healing**	**Heart Problem**_____

Other _____

Family physician: _____**Phone#**_____

Referred by: _____

Have you seen a Podiatrist before? (If yes, name of the podiatrist) _____

Pharmacy: _____Address _____Phone #_____

Current medications (DO NOT SKIP THIS SECTION) ☐ LIST PROVIDED ☐ NOT CURRENTLY TAKING MEDICATIONS

1. _____ **2.** _____ **3.** _____

4. _____ **5.** _____ **6.** _____

7. _____ **8.** _____ **9.** _____

DO YOU HAVE ANY ALLERGIES: □ Yes □ No

☐ Penicillin ☐ Codeine ☐ Cortisone ☐ Anesthetics ☐ Aspirin ☐Vicodin ☐ Iodine ☐ latex ☐ antibiotic _____

☐ Sulfa drugs OTHER: _____

DO YOU SMOKE? ☐ Yes ☐ No ☐ Former packs/Day_____ How many years? _____

►►Patient or guardian Signature: _____**DATE:** _____