



WOLF RIVER FAMILY FOOTCARE, PLLC
 Carl J. Siciliano, DPM Adam C. MacEvoy, DPM
 7424 Hwy 64, Suite 119, Bartlett, TN 38133
 Ph:(901) 381-2800 Fax:(901) 381-2677

Please have picture identification and insurance cards available for copying.

PATIENT INFORMATION

NAME	MALE	FEMALE	M S W D CHILD
		MARITALSTATUS	
ADDRESS		CITY/STATE/ZIP	
HOME PHONE #	CELL PHONE #	EMAIL	
DATE OF BIRTH	AGE	SS#	
EMPLOYER		OCCUPATION	
EMPLOYER ADDRESS		PHONE #	
RESPONSIBLE PARTY		DATE OF BIRTH	
ADDRESS		SS#	
<small>(IF DIFFERENT FROM PATIENT)</small>			
EMPLOYER		EMP ADDRESS & PHONE #	
EMERGENCY CONTACT		PHONE #	

PLEASE LIST THE PERSON(S), IF ANY, WHOM WE MAY INFORM ABOUT YOUR GENERAL MEDICAL CONDITION AND YOUR DIAGNOSIS (INCLUDING TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS:

NAME	PHONE #
NAME	PHONE #

MAY WE (Wolf River Family Footcare, PLLC) LEAVE CONFIDENTIAL MESSAGES SUCH AS APPOINTMENT REMINDERS OR LAB RESULTS ON YOUR ANSWERING MACHINE OR VOICEMAIL? YES NO

PLEASE BE AWARE THAT A WIRELESS CELL PHONE IS NOT A SECURE AND PRIVATE LINE

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY		SECONDARY INSURANCE COMPANY	
SUBSCRIBER NAME		SUSCRIBER NAME	
ID OR POLICY #	GROUP #	ID OR POLICY #	GROUP #
SS#	DATE OF BIRTH	SS#	DATE OF BIRTH

I, the undersigned, certify that I(or my dependent) have insurance with the above listed insurance company, and assign directly to Wolf River Family Footcare, PLLC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Wolf River Family Footcare, PLLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. In Medicare assigned cases, Wolf River Family Footcare, PLLC, agrees to accept the charge determination of the Medicare carrier as the full charge, and I will only be responsible for non-covered services, deductibles and coinsurance, which are based upon the charge determination of the Medicare carrier.

SIGNATURE OF SUBSCRIBER OR BENEFICIARY	DATE
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Who may we thank for referring you to our office? _____

MEDICATIONS

Please list all medications and include vitamins, supplements, and over the counter drugs:

Females: Do you take oral contraceptives? YES NO

PHARMACY NAME PHONE #

MEDICAL HISTORY

FAMILY PHYSICIAN NAME PHONE#

PLEASE LIST ANY HOSPITALIZATIONS AND/OR SURGERIES YOU HAVE HAD:

PLEASE INDICATE WITH A CHECK MARK IF YOU NOW HAVE OR HAVE HAD ANY OF THE FOLLOWING:

Aids/HIV Anemia Arthritis Artificial Heart Valves or Joints Asthma Back Problems Bleeding Disorders

Cancer Chemical Dependency Chest Pain Circulatory Problems Diabetes Epilepsy Gout Heart Disease

Hepatitis or Jaundice High Blood Pressure Kidney Problems Liver Disease Psychiatric Problems Phlebitis

Respiratory Disease Shortness of Breath Stroke Ulcers Other

ALLERGIES

ARE YOU ALLERGIC TO: Penicillin Sulfa Codeine Demoral Iodine Aspirin Adhesive tape

Local Anesthetics Anti-coagulant therapy Seafood Other:

PODIATRIC HISTORY

Have you ever been to a podiatrist? _____ Date of Last Visit and Name _____

Please indicate which foot or ankle problems you now have or have had in the past:

Ankle pain or swelling now past Athlete's Foot now past Bunions now past

Corns & Callouses now past Numbness now past Cramps/Burning now past

Flat Feet now past Heel Pain now past Ingrown Toenail now past

Neuromas now past Plantar Warts now past Other

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

SIGNATURE DATE

