WELCOME

Clinton F. Holland, DPM

Emergency FootCare, PC • 601 E. Hampden Ave., Suite 410 • Englewood, CO 80113-2770

phone (303) 789-9255 • fax (303) 789-0135

PATIENT INFORMATION

Date _____

Name _____

S.S # _____

Address _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Shoe size _____

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Primary Care Physician _____

Phone # (_____) _____ Date Last Visited? _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Work Phone (_____) _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (include foot, ankle, knee, thigh and hip complaints.)

_____

_____

_____

Have you ever been to a podiatrist before?
☐ Yes ☐ No

If yes, please list

Name _____

Last visit _____

Is there any personal or family history of diabetes?
☐ Yes ☐ No

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____

Athletic activities in which you participate (please list and indicate frequency)

_____

_____

_____

INSURANCE

Primary Insured _____

Relationship to Patient _____

Primary Insurance _____

Policy # _____

Group # _____

Insurance Phone # (_____) _____

Secondary Insurance _____

Policy Holder _____

Birthdate _____ SS# _____

Relationship to Patient _____

Policy # _____

Group # _____

Insurance Phone # (_____) _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. Clinton F. Holland all insurance benefits, if any, otherwise payable to me for services rendered. I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions

The above named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for issued services. This consent will end when my current treatment plan is completed at one year from the date I agree below.

MEDICARE AUTHORIZATION

I request full payment of authorized Medicare benefits be made either to me or on my behalf to Emergency Footcare, PC / Dr. Clinton F. Holland for any services rendered to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare Services and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Please print name of Beneficiary, Guardian or Personal Representative

_____
Date Relationship to Beneficiary

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

Ankle Pain	☐ Yes ☐ No	Foot or Leg Cramps	☐ Yes ☐ No
Athlete's Foot	☐ Yes ☐ No	Heel Pain	☐ Yes ☐ No
Bunions	☐ Yes ☐ No	Ingrown Toenails	☐ Yes ☐ No
Corns and Calluses	☐ Yes ☐ No	Plantar Warts	☐ Yes ☐ No
Cramps or Numbness in Foot or Legs	☐ Yes ☐ No	Swelling in Ankles or Feet	☐ Yes ☐ No
Flat Feet	☐ Yes ☐ No	Tired Feet	☐ Yes ☐ No

My pain/discomfort is:

☐ Shooting pain ☐ Sharp pain ☐ Aching pain ☐ Itching ☐ Tingling
☐ Throbbing pain ☐ Burning pain ☐ Dull pain ☐ Tenderness ☐ Numbness

How long ago did the problem start? ____days, weeks, months, yrs ago

The pain from my problem occurs:

__ while walking __ while not walking __ and/or _____