FootDoctors
Put Your Feet in Our Hands

Herkimer Office
250 E. State Street
Herkimer, NY 13350-1901
Phone: (315) 866-3668

New Hartford Office
610 French Road
New Hartford, NY 13413
Phone: (315) 793-3668

PERSONAL INFORMATION

Date: ____/____/____
Patient's Name: _____ DOB: _____
(Last) (First) (MI)

Male/Female Single/Married/Widowed
Phone: _(___)_____ Cell: _(___)_____

Email: _____
Address: _____
City: _____ State: _____ Zip: _____
Employer: _____ Address: _____
Work Phone: _(___)_____ Ext. _____

How did you hear about the practice? (circle one)
Internet/Google_____ Friend/Family_____ Doctor Referral (who?)_____
Insurance Website_____ Facebook_____ Other_____

INSURANCE INFO : RECEPTIONIST WILL COPY CARD

Ins. Co. Name: _____ Policy #: _____ Group # _____
Subscriber: _____ DOB: _____ Relationship: _____
Subscriber's Employer: _____

MEDICAL INFORMATION

Local Pharmacy : _____ Phone #: _(____)_____
Patient's Primary Physician: _____
Address: _____
Phone #: _(____)_____

Do you have any advance directives? Yes No (Please circle)

Medications currently using: _____
_____
_____

Allergies: (eg. Medications, Latex, Tape, Local Anesthetics, etc.)
_____
_____

Patient's Medical History: (eg. Heart Disease, Arthritis, Diabetes, etc.)
_____
_____

(OVER)

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Past Surgery History: _____

_____

Any Family History (Mother, Father, Brothers, Sisters): Cancer: _____
Diabetis: _____ Heart Disease: _____

Do you use tobacco? Yes No (Please Circle) Former Smoker? Yes No (Please Circle)
Quit how long ago? _____ Use of alcohol? _____

Height: _____ Weight: _____ Shoe Size: _____

Have you fallen 2 or more times in the past year? Yes No (Please Circle)

If yes, how many times and did you sustain an injury? _____

Have you ever received a pneumococcal vaccination? Yes No (Please Circle)

Have you received the Covid vaccination? Yes No (Please Circle)
If yes, which one? _____ Did you receive both 1st and 2nd shot? _____
Did you receive the Covid booster shot? Yes No (Please Circle)

Have you been in a hospital or long-term care facility within the past 30 days? Yes No (Please Circle)

Have you been out of the country in the last 30 days? Yes No (Please circle) If Yes, How long ago? _____

Reason for visit today: _____

_____

How long has this been going on? _____
What is your pain level today? 0 to 10 (0 no pain, 10 being worst pain possible) _____

I hereby authorize FootDoctors to release medical information necessary for filing claims for services rendered to the insurance companies listed above. I hereby authorize the insurance companies listed above to make payment benefits directly to FootDoctors for services rendered by him/her.

Signature: _____ Date: _____