Basso Foot & Ankle Clinics

Douglas Basso, DPM

Welcome to our practice! Thank you for trusting Basso Foot & Ankle Clinics (Basso Clinics) with your foot health.

NEW PATIENT INTAKE FORM

Name: Gender:M F

Date of Birth: Age Social Security #:

Address: City: State: Zip

Home Phone #: Cell Phone:

Marital Status: Single Married Divorced Widowed Partner Legally Separated

Emergency Contact: Phone: Cell Phone:

E-Mail Address: Primary Spoken Language

Employment Status: Full-Time Part-Time Not Employed Student

Race:

American Indian or Alaska Native Native Hawaiian or other Pacific Islander

Asian Caucasian Black or African American

How did you hear about us?

Primary Care Physician: Referred by:

Cardiologist: Endocrinologist:

Nephrologist: Rheumatologist:

***Please describe your foot/ankle problem (include date of injury if applicable) ***

How long has the problem been present?

Have you had any treatment or taken anything for it?

Have you seen someone for this already?No Yes Whom?

Have you had any prior foot/ankle problems? If yes, please describe: No Yes

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WELCOME TO OUR OFFICE!

ALLERGIES

Please check all allergies:

☐ Medications:

☐ Foods:

☐ Tapes or Topical Skin Sensitivity ☐ Other:

What types of reactions have you experienced?

MEDICATIONS

Please list all medications and the dosages:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Personal Medical History:

****Check those that apply to you now or have applied to you in the past****

☐	Frequent Headache/Migraines	☐	Anemia/Blood Disorders
☐	Liver Disorder	☐	Pneumonia
☐	Kidney Disease	☐	Drug/Alcohol Abuse
☐	Dialysis M W F or T TH SA	☐	Epilepsy or Seizures
☐	Diabetes Average Blood Sugar HgbA1c	☐	Prolonged Bleeding Time
☐	Asthma	☐	Stomach/Ulcer Disorder
☐	Emphysema	☐	Thyroid/Parathyroid Disease
☐	Heart Trouble	☐	High Blood Pressure
☐	Stroke	☐	Arthritis
☐	Chest Pain on Mild Exertion	☐	Psychiatric Treatment
☐	Gout	☐	Emotional Problems/Tension
☐	BLOOD CLOTS	☐	Asthma/Hay Fever/Shortness of Breath
☐	Tumor/Abnormal Growth/Cancer	☐	Sexually Transmitted Disease
☐	Ear, Nose, Throat Disorder	☐	Prostate Disorder
☐	Hepatitis/HIV	☐	Other

Preferred Pharmacy:

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SURGICAL HISTORY

Surgical Procedures/Serious Injuries/Illnesses	Year	Physician	Hospital

Has any **family member** had any of the following (please indicate relationship)

Cancer: Diabetes:

Heart Trouble: High Blood Pressure:

Kidney Disease: Mental or Emotional Disease:

Stroke: Tuberculosis:

Arthritis: Emphysema:

Blood clots: Other:

PATIENT INFORMATION

Do you smoke currently? Yes No How many packs per day? For how many years?

Have you smoked previously? Yes No When did you quit?

Number of caffeine drinks per day? Amount of alcohol consumed per week

For women only: Are you pregnant? How many months?

Please complete the following:

Height: **Weight:** **Shoe size:** Occupation:

Is there any other information you would like us to be aware of: No Yes

Please describe:

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I hereby authorize direct payment of surgical and medical benefits on my behalf to the provider of these services. I understand that I am personally responsible to the physician for charges not covered by my insurance agreement.

I permit a copy of this assignment to be used in place of the original for purposes of billing

I acknowledge that if my insurance requires a referral, whether it be paper or electronic, that I am responsible for getting an up to date and valid referral. I understand that failure to do so may result in my charges being my responsibility and that payment will be due from me directly.

The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital generated. Also, I herby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition, to use x-ray examination, or photographs as necessary.

I give Dr. Douglas Basso permission to obtain and release medical information to insurance companies and referring physicians. I have read the following and understand and agree to Douglas Basso, DPM's office policy.

Signature of Patient of Legal Guardian

Date