Utah Foot and Ankle
Taylor G. Wright, D.P.M.

740 East 3900 South, Suite 108
Salt Lake City, UT 84107

Patient Information

Name _____

Date of Birth _____ Age _____ M/F: _____

Social Security # _____-_____-_____

Address _____

City _____ State _____ Zip _____

Phone:

- Home _____
- Work _____
- Cell _____

Email _____

Marital Status _____

- Name of Spouse (Parent/Guardian):
  _____

Occupation _____

Employer _____

- Address_____
  _____
- Phone _____

Family Physician _____

- Phone _____

Preferred Pharmacy _____

- Phone _____

Emergency Contact _____

- Relationship _____
- Phone _____

Referred by _____

Insurance

Company _____

ID# _____

Subscriber's Name _____

Birthday _____ SS# _____

Relationship to patient:

- ☐ Self
- ☐ Child
- ☐ Spouse
- ☐ Other _____

Is the patient covered by a secondary insurance: Y N

Company_____

ID# _____

Subscriber's Name _____

Birthday _____ SS# _____

Relationship to patient:

- ☐ Self
- ☐ Child
- ☐ Spouse
- ☐ Other _____

Authorization to Release Information and Assignment of Benefit.

1. I authorize the release of any and all medical information necessary to process this claim.
2. I hereby authorize Taylor G. Wright, D.P.M., to apply for benefits on my behalf for covered services rendered by them, or by their order. I request that payment from my insurance company be made directly to Associated Foot Surgeons.
3. I certify that the information I have reported with regard to my insurance coverage is correct.
4. I understand that I am personally responsible for payment of services rendered.
5. I permit a copy of this authorization to be used in place of the original.
6. I acknowledge that I have been provided with a copy of the Notice of Privacy Practices to read.

_____ _____

Signature (Parent or Guardian if minor) Date

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GENERAL HEALTH INFORMATION

Shoe Size _____ Current Weight: _____ Height: _____

ALLERGIES:
Medications: (Please list)

_____

Food: (Please list)

_____

Tape? _____ Betadine (iodine)? _____ Other: _____
Have you had any problems taking aspirin or Ibuprofen (Advil, Motrin)? ___Yes ___No
Any problems with local anesthetics (Novocaine, Lidocaine)? ___Yes ___No

Medication: (Please list all medications currently taking)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list any major surgeries you have had:

_____ _____
_____ _____

MEDICAL HISTORY: Circle any that apply

Acid Reflux	Fibromyalgia	Neuropathy
Anemia	Gout	Open Sores
Arthritis	Heart Attack	Pneumonia
Asthma	Heart Disease/Failure	Polio
Back Trouble	Hepatitis	Rheumatic Fever
Bladder Infections	HIV+/AIDS	Sickle Cell Disease
Abnormal Bleeding	High Blood Pressure	Skin Disorder
Blood Clots	Kidney Disease	Sleep Apnea
Blood Transfusion	Liver Disease	Stomach Ulcers
Bronchitis/Emphysema	Low Blood Pressure	Stroke
Cancer	Migraine Headaches	Thyroid Disease
Diabetes	Mitral Valve Prolapse	Tuberculosis

Other Conditions: Please list

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FAMILY HISTORY:

( ) Cancer

( ) Diabetes

( ) Heart Disease

( ) Bleeding Disorder

( ) Neurological Disorder

( ) Rheumatoid Arthritis

( ) Stroke

( ) Bunions

( ) Hammertoes

( ) Flat feet

( ) Circulation problems in legs or feet

() Other: _____

Do you smoke? __ No __ Yes, # packs/day: _____

Did you previously smoke? __ No __Yes, # years:_____ # packs/day: _____

Do you drink alcohol or beer? __No __Yes

__ Light usage __Moderate __ Heavy

Employment: __ Sits at job __ Stands at job __ Stands and walks at job __ Retired

I have answered the questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_____ _____

Print name of Patient, Parent, or Guardian Signature

_____ _____

If other than patient, Relationship to the patient Date

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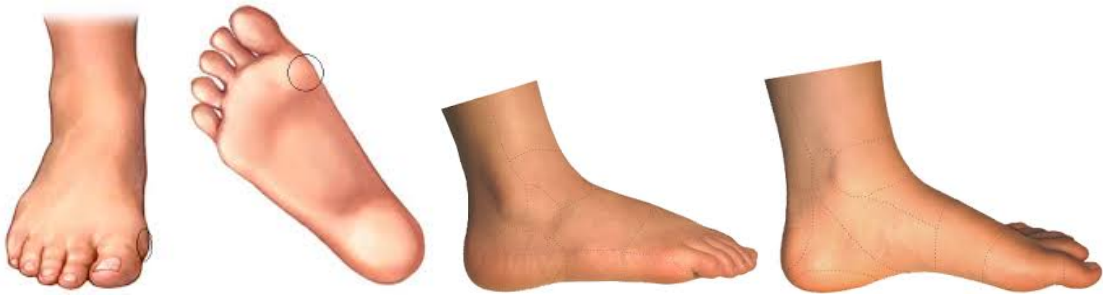
MEDICAL INFORMATION

Describe your foot problem:

_____
_____
_____
_____

PLEASE INDICATE, WITH AN "X", WHERE THE PROBLEM IS LOCATED



R L BOTH R L BOTH R L BOTH R L BOTH

How long has it been bothering you? _____ Days _____ Weeks _____ Years

Is the problem due to an injury? ___Yes ___No

If yes, what was the date of injury? _____

Where did the injury occur? ___Home ___Work ___Other:_____

Any past problems of your feet and ankles? ___Yes ___ NO

If yes, please explain: _____

_____

Any past surgical procedures on your feet and ankles? ___Yes ___No

Name of surgery/surgeries performed: _____

_____