Johnston Foot and Ankle Clinic
5335 Merle Hay Rd
Johnston, IA 50131

PATIENT INFORMATION

First Name: _____ Last Name: _____ M _____ Nick Name: _____

Address: _____ City: _____ ST: ___ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Marital Status: _____ Social Security Number: _____ Date of Birth: _____

Preferred Language: _____ Sex: _____Race: _____

Emergency Point of Contact Name: _____ Relationship: _____

Emergency Point of Contact Phone: _____

Do we have permission to talk to this person regarding your health? ☐Yes ☐No

RESPONSIBLE PARTY (GUARANTOR)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ ST: ___ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Social Security Number: _____ Date of Birth: _____ Relationship to Patient: _____

ADDITIONAL INFORMATION

Primary Care Physician _____ Last Seen: _____

Address: _____ City: _____ ST: ___ Zip: _____

Preferred Pharmacy: _____

Address: _____ City: _____ ST: ___ Zip: _____

What is your occupation? _____

How much time do you spend on your feet? _____

What type of regular exercise or activities are you involved in? _____

When did the problem start? _____

What treatments have you tried? _____

Please list any/all medications and dosages: (If you do not take any medications leave blank)

Medication	Dose	Medication	Dose

PAST MEDICAL HISTORY (Please check all that apply)

- ☐Heart Disease
- ☐Endocarditis (Heart valve infection)
- ☐Hemodialisis
- ☐Hypertension
- ☐Kidney Disease
- ☐Liver Disease
- ☐Pre-Diabetic or Diet controlled Diabetes
- ☐Poorly controlled diabetes
- ☐Diabetes controlled with oral medication
- ☐Diabetes controlled by Insulin
- ☐Type 1 Diabetes
- ☐History of DVT or Blood Clot
- ☐Pulmonary Embolism
- ☐Clotting disorder (factor V etc.)
- ☐Prosthetic Joint(s)
- ☐Peripheral Vascular Disease
- ☐Peripheral Neuropathy or Numbness in feet
- ☐Foot Ulcer
- ☐Rheumatoid Arthritis
- ☐Other _____

Do you have any other medical problems we should be aware of? _____

_____

PAST SURGICAL HISTORY

- ☐**Knee Arthroscopy** ☐Right ☐ Left ☐Both
- ☐**Knee Replacement** ☐ Right ☐ Left ☐Both
- ☐**Hip** ☐Right ☐ Left ☐ Both
- ☐**Foot** ☐Right ☐ Left ☐Both
- ☐**Ankle** ☐ Right ☐Left ☐Both

Do you have any allergies? (Please describe) _____

What is your: Height _____ Weight _____

How did you hear about us? _____

I/We do hereby consent to and authorize the performance of any/all treatments, surgeries and/or medica services deemed advisable by Dr. Dana L. Plew, DPM at Johnston Foot & Ankle Clinic, to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and/or my dependent(s) regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses, and attorney fees incurred to collect any amount I may owe. I also hereby authorize Johnston Foot & Ankle to release any/all information requested by insurance companies and/or its representatives, collection agencies and/or any attorney's office and/or any physician, surgery center or hospital. The signature below will also count as my "signature on file" for any/all insurance purposes. I fully understand this agreement and consent will continue until cancelled by me in writing.

Print Name of Patient or Responsible Party: _____ Date: _____

Signature of Patient or Responsible Party: _____ Date: _____

NO SHOW POLICY FOR JOHNSTON FOOT AND ANKLE CLINIC

As a courtesy to our office as well as the patients that are waiting to schedule with the physician, please give us at least 24-hours notice if needing to reschedule your appointment. ***If you do not cancel or reschedule your appointment with at least 24-hours notice, we may assess a $50.00 "no show" service charge to our account.***

"I acknowledge that I read and understand this policy".

Signature of Patient or Responsible Party: _____ Date: _____

Complete the form and email to johnstonfootandankleclinic@gmail.com or print and bring with you to your appointment.