

Chattanooga Foot Specialists, PLLC
Lisa Wamack, DPM

First Name _____ M.I. _____ Last Name _____
Address _____ Apt.# _____
City _____ State: _____ Zip: _____
Home Phone _____ Cell Phone: _____ Work Phone: _____
Birthdate: _____ Age: _____ Marital Status: _____
Sex _____ Social Security # _____
Employer: _____ Occupation: _____

Insurance Information

Insurance _____ Identification # _____
Group # _____ Referral Required _____
Cardholder's Name _____ Cardholder SSN# _____
Relationship to cardholder _____ Cardholder's Birthdate _____

Secondary Ins. _____ Identification Number: _____
Group # _____ Cardholder's Name _____
Cardholder's SSN _____ Cardholder's Birthdate _____

Emergency Contact

Name _____ Relationship _____
Home Phone: _____ Cell: _____ Work: _____
Foot Problem: _____
Primary Care Physician: _____
How did you hear about us? _____

Consent for Treatment

I consent for treatment of the above named patient. I authorize the release of all medical records to the referring and primary care physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records if necessary. I acknowledge full responsibility for services rendered by Dr. Wamack on the date of service. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of my payment. I further authorize and request that insurance payments be made directly to Dr. Wamack. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Signature: _____ **Date:** _____

CHATTANOOGA FOOT SPECIALISTS, PLLC

Name: _____

Date: _____

Medical History

Circle Yes or No

Y or N Anemia

Y or N Arthritis

Y or N Asthma

Y or N Bowel Problems

Y or N Cancer

Y or N Circulation Problems

Y or N Excessive Bleeding

Y or N Diabetes

Y or N HIV/AIDs

Y or N Healing problems

Y or N Heart attack

Y or N Heart Failure

Y or N Hepatitis

Y or N High Blood Pressure

Y or N Kidney Problems

Y or N Liver Problems

Y or N Lung Disease

Y or N Phlebitis/blood clots

Y or N Rheumatic Fever

Y or N Stomach ulcers/reflux

Y or N Stroke

Please answer the following questions:

Are you allergic to any medications? Y or N

If yes, name of medications _____

Are you taking any medications? Y or N

If yes, please list the names of the medications.

Have you ever had surgery? Y or N

If yes, what type and when?

Do you smoke? Y or N How much? _____ How long? _____

Any medical problems in the family? Y or N

If yes, who and what were the conditions? _____