# Absolute Foot & Ankle Specialists


Dr. Luz E. Colon, DPM

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## Patient Information

Name/Nombre: _____D.O.B/Fecha De Nacimiento:_____

Address/Direccion:_____

Cell #:_____ Home #:_____

Emergency Contact:_____

Primary Doctor/Doctor Primario: _____

Medications: _____

Pharmacy/Farmacia:_____

Social Security: _____ Insurance Company:_____

Medicare:_____ Medicaid:_____

How did you hear about our clinic? _____

I, the undersigned, have insurance coverage with and assign directly to Absolute Foot & Ankle Specialists, all benefits, if any, otherwise payable to me for service rendered. I understand that i am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the use of this signature on all my insurance submissions.

Patient Signature:_____

Date:_____

# Absolute Foot & Ankle Specialists

Patient Medical History/Historial Medico

What is the reason for your visit today? _____

Cuál es la razon de su visita hoy?_____

Allgeries/Alergias:_____

Previous Surgeries/ Historial de Cirugias :_____

Do you smoke? (Circle) Yes or No Do you drink ? (Circle) Yes or No

Do you have any of these medical conditions? ( Usted tiene alguna de estas condiciones medicas?)

Diabetes ___

Arthritis ___

Asthma ___

Cancer___

Gout (Gota) ___

Rash (Picason) ___

Foot/Leg Cramps (Calambres) ___

Thyroid Disease ___

HIV/AIDS ___

High Blood Pressure (Presion Alta) ___

Stroke(Derrame celebral) ___

Heart Disease (Problemas del Corazon) ___

Circulation Problems (Problemas De Circulacion) ___

Varicose Veins (Venas Varicosas) ___

Swelling of feet/Ankles ( Tobillos/Pies Inchados) ___

Neuropathy ___

Hepatitis ___

Kidney Disease (Enfermedad del riñon) ___

## Consent

I authorize Absolute Foot & Ankle Specialists to release information requested by my insurance company acquired in the course of my examination, diagnosis and treatment on my feet and legs. Doy el permiso a la compania Absolute Foot & Ankle Specialists para el administre del tratamiento, procedimiento y el diagnostico de mis pies y piernas.

Patient Signature:_____

Date:_____