Established Patient Update Packet

Complete this packet if it has been 1-3 years since your last visit. If it has been more than 3 years since your last visit, please complete our New Patient Packet instead.

Patient full name: _____

Date of birth: _____ Today's date: _____

Contact Information Updates

Have your address, phone number, email address, or emergency contact changed since your last visit?

☐ No changes ☐ Yes - please complete the changed information below

Address: _____

City: _____ State: _____ ZIP: _____

Cell phone: _____ Other phone: _____

Email: _____ Emergency contact phone: _____

Emergency contact name: _____ Relationship: _____

Insurance Update - Complete Only for Changed Insurance

Has your insurance changed since your last visit? ☐ No ☐ Yes

Please bring your current insurance card(s) to every visit. If your insurance has changed, complete the information below.

Primary insurance: _____ Member / ID number: _____

Secondary / supplemental: _____ Member / ID number: _____

Complete below only if the policyholder/subscriber has changed or is someone other than the patient:

Subscriber name: _____ Date of birth: _____

Relationship to patient: _____

Communication & Privacy Preferences - Changes Only

☐ No changes to my current communication or privacy preferences.

Text messages: ☐ Start/continue text messages ☐ Stop text messages

☐ Voicemail: Brief callback message only ☐ Do not leave voicemail messages ☐ Detailed medical information may be left

☐ Revoke all previously authorized people ☐ Add/change authorized people on next page

Authorized People / Health Updates

Authorized People - Add or Change Only

Person 1 name: _____ Relationship: _____

Phone: _____ Email: _____

☐ Appointments ☐ Billing / insurance

☐ Medical information ☐ All of the above

Person 2 name: _____ Relationship: _____

Phone: _____ Email: _____

☐ Appointments ☐ Billing / insurance

☐ Medical information ☐ All of the above

Medical History Update

☐ No significant changes to my medical history since my last visit.

Since your last visit, have you had a new diagnosis, significant change, hospitalization, surgery, or other important health event? Check all that apply.

☐ Heart disease ☐ High blood pressure ☐ Irregular heartbeat

☐ Stroke / TIA ☐ Sleep apnea / CPAP ☐ Diabetes

☐ Neuropathy ☐ Other neurologic condition ☐ Kidney disease

☐ Liver disease / hepatitis ☐ Cancer or cancer treatment ☐ Rheumatoid arthritis

☐ Other autoimmune / immune condition ☐ Organ transplant ☐ GI bleeding / new inability to take NSAIDs

☐ Hospitalization / emergency-room visit ☐ New surgery or procedure ☐ Other significant new diagnosis or health change

Details / approximate date: _____

_____

Diabetes Update - If Diabetic

☐ Type 1 ☐ Type 2 ☐ Other ☐ Unsure | Last A1c: _____ ☐ Unknown

Approximate date of last A1c: _____

Allergy / Health / Medication Updates

Allergy Update

☐ No changes to my allergies

☐ New or changed allergy information

Medication / substance	Reaction

Other Relevant Health Updates

Current nicotine use: ☐ None ☐ Yes

If yes, type / amount: _____

Pregnant or pregnancy possible: ☐ No ☐ Yes ☐ Unsure ☐ N/A

Breastfeeding: ☐ No ☐ Yes ☐ N/A

Medication Update

☐ No medication changes since my last visit

☐ My medications have changed

List medications that were started, stopped, or had a dose changed since your last visit. Please include the current dose when known.

Medication	Current dose	Started / Stopped / Dose changed

Foot, Leg and Mobility Update

Foot and Leg Changes

Since your last visit, have you developed or experienced any of the following?

- ☐ None of these
- ☐ Poor circulation / peripheral arterial disease
- ☐ Arterial stent / bypass / angioplasty
- ☐ Foot or leg ulcer / slow-healing wound
- ☐ Toe / foot / leg amputation
- ☐ Chronic swelling / lymphedema
- ☐ DVT / pulmonary embolism
- ☐ MRSA infection / osteomyelitis
- ☐ Foot or ankle fracture
- ☐ Osteoporosis / stress fracture
- ☐ Repeated ankle sprains
- ☐ Varicose veins / venous disease
- ☐ New numbness / neuropathy
- ☐ Other

Details, side and approximate dates:

_____

_____

_____

Circulation Symptoms

Calf pain / cramps with walking that improves with rest? ☐ No ☐ Yes ☐ Unsure

Foot pain in bed that improves by hanging the foot down? ☐ No ☐ Yes ☐ Unsure

Mobility and Fall Risk

Current assistive device:

- ☐ None
- ☐ Cane
- ☐ Walker
- ☐ Crutches
- ☐ Wheelchair
- ☐ Other

Have you fallen during the past year? ☐ No ☐ Yes

Do you feel unsteady when standing or walking? ☐ No ☐ Yes

Can you see and reach your feet? ☐ Yes ☐ No

If someone helps with your foot care, who? _____

Current Foot or Ankle Problem

What Brings You In Today?

☐ Routine foot care / no new foot or ankle problem

Main concern: _____

☐ Right ☐ Left ☐ Both

When did it start? _____ Injury or trigger: _____

Pain level: ____ / 10

☐ Improving ☐ Unchanged ☐ Worsening

Symptoms

☐ Pain ☐ Swelling ☐ Stiffness

☐ Numbness ☐ Burning / tingling ☐ Weakness

☐ Ankle gives way ☐ Wound / drainage ☐ Nail / skin problem

☐ Other: _____

What makes it better or worse?

_____

_____

Previous treatment/testing since last visit:

_____

Treatment goal / activities affected:

_____

Review and Acknowledgments

General Consent for Evaluation and Treatment

I consent to podiatric evaluation and general medical treatment by the healthcare providers of About Feet Podiatry Center and, when applicable, AFP Surgery Center. This general consent does not replace procedure-specific informed consent for surgery or other procedures requiring separate consent.

Electronic Medication History Consent

I consent to About Feet Podiatry Center and its healthcare providers obtaining my prescription medication history electronically from pharmacies, pharmacy benefit managers, health plans, and other available medication-history sources for treatment and medication reconciliation.

Financial Responsibility

I acknowledge that the current Financial Responsibility Policy of About Feet Podiatry Center and, when applicable, AFP Surgery Center applies to my care. I understand that I am responsible for amounts properly assigned to me under my insurance benefits, applicable payer contracts, and applicable law. The current policy is available on our website and in the office upon request.

Patient Certification

I have reviewed the information in this Established Patient Update Packet and, to the best of my knowledge, the information I provided is complete and accurate. I have identified changes to my health, medications, allergies, contact information, insurance, and communication/privacy preferences where applicable.

Patient name: _____

Patient / Legal Representative signature: _____

Relationship to patient, if applicable: _____ Date: _____

Staff Use Only

Date of last visit: _____ Staff initials: _____

- ☐ 1-3 years since last visit
- ☐ Insurance cards reviewed/scanned
- ☐ Medication list reconciled
- ☐ Allergies reconciled
- ☐ Demographics updated in patient record
- ☐ Communication/privacy changes entered