PATIENT INFORMATION

Date_____
SS/HIC/Patient ID#_____
PaTIENT Name_____
Last Name
_____
First Name Middle Initial
Address_____
City_____
State_____ Zip_____
E-mail_____
Sex ☐ F ☐ M Age_____ Birthdate_____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for____years

Patient Enployer/School_____
Employer/School Address_____
_____
Employer/School Phone(_____)_____
Spouse's Name_____
Birthdate_____ SS#_____
Spouse's Employer_____
Whom may we thank for referring you?_____

PHONE NUMBERS

Home Phone(_____)_____
Cell Phone(_____)_____
Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT
Name_____
Relationship_____
Home Phone(_____)_____
Work Phone(_____)_____

INSURANCE

Who is responsible for this account?_____
Relationship to Patient_____
Insurance Co._____
Group #_____
Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber's Name_____
Birthdate_____ SS#_____
Relationship to Patient_____
Insurance Co._____
Group #_____

INSURANCE ASSIGNMENT AND RELEASE
I certify that I have insurance coverage with_____
Name of Insurance Company(ies)
and asssign directly to Dr._____
All insurance benefits, if any, otherwise to me for services rendered. I understand that I am financially responsible for all charges whether not to paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION
I request that payment of authorized Medicare benefits and, if applicable, Medigap
benefits, be made either to me or on my behalf to_____
Name of
_____for any services funished to me by that provider.
Doctor Or Clinic
To the extent permitted by law, I authorize any holder of medical of other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits for related services.

_____
Signature of Beneficiary, Guardian or Personal Representative
_____
Please print name of Beneficiary, Guardian of Personal Representative
_____ _____
Date Relationship to Beneficiary

PODIATRIC HISTORY

What is the chief complaint for which you came To be treated?(Include foot, ankle,knee,thigh, and hip complains.)
_____
_____
_____
Have you ever been to a Podiatrist before?
☐ Yes ☐ No
If yes, please list.
Name_____
Last visit_____

Is there any personal or family history of diabetes?
☐ Yes ☐ No
Your occupation_____
Cigarette/Tobacco use_____
Years smoked_____
Athletic activities in which you participate(please list and indi cate frequency)
_____
_____
_____

Please indicate which foot problems you Now have or have had in the past

Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Calluses	☐ Yes	☐ No
Cramps or Numbness in feet or legs	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Heel Pain	☐ Yes	☐ No
I ngrown Toenails	☐ Yes	☐ No
Plantar Wars	☐ Yes	☐ No
Swelling in Ankles or Feet	☐ Yes	☐ No
Tired Feet	☐ Yes	☐ No

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Allergies to Anesthetics	☐ Yes	☐ No	Eye Problems	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Allergies to Medicine or Drugs	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Foot or Leg Cramps	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Artificial Heart Valves or Joints	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Swelling in Ankles, Feet	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis or Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tired Feet	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Chronic Diarrhea	☐ Yes	☐ No	Neuropathy	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No	Weight Loss,unexplained	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Ear Problems	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Surgeries you have had_____

_____

_____

Hospitalization other than for the surgeries listed_____

_____

_____

Family physician_____ Last visit date_____

Are you now, or have you been, under any doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain_____

_____

_____

MEDICATION

Include prescriptions, over-the-counter medications and vitamins_____

_____

_____

Pharmacy Name(s)_____

Pharmacy Phone(s)_____

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

☐ Adhesive/Tape
☐ Anticoagulant Therapy
☐ Aspirin
☐ Codeine
☐ Demerol
☐ Iodine
☐ Local Anesthetics
☐ Novocaine
☐ Penicillin
☐ Seafoods
☐ Sulfa

Other _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistant or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Date

_____ _____

Pleasure print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient