

WELCOME

Thank you for selecting our podiatric care team! We will strive to provide you with the best possible foot care. To help us meet all of your foot care needs, please fill out this form *COMPLETELY* in ink. If you have any questions or need assistance, please ask us. We will be happy to help.

PATIENT INFORMATION AND HISTORY

PLEASE PRINT

PATIENT NAME: _____ MALE / FEMALE _____ MAR / SING / DIV / WID _____
 LAST FIRST MI
 BIRTH DATE: _____ AGE: _____ SOC SEC # _____ PHONE # (H) _____ (W) _____
 HOME ADDRESS: NO. & STREET _____ CITY _____ ST _____ ZIP _____
 E-MAIL: _____
 EMPLOYER _____ OCCUPATION _____
 WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____ RELATIONSHIP _____
 EMERGENCY, CONTACT: _____ PHONE # _____ RELATIONSHIP _____
HOW DID YOU LEARN ABOUT THE PRACTICE? _____
PRIMARY CARE PHYSICIAN (PCP) NAME, ADDRESS & PHONE # _____

Are you covered under health insurance benefits sponsored by your employer? • YES • • NO •
Are your covered health insurance benefits sponsored by your spouse's or parent's employer? • YES • • NO •
Primary Insurance Company: _____ **Additional Insurance Company:** _____
 Name of Insured: _____ Name of Insured: _____
 Relationship to Patient: ___ Self ___ Spouse ___ Parent Relationship to Patient: ___ Self ___ Spouse ___ Parent
 Birth Date of Insured: _____ Birth Date of Insured: _____
 Social Security #: _____ Social Security #: _____

What is your Primary reason for today's visit (body part(s) and brief description of problem): _____

Is the problem related to Pain / Instability / Weakness / Other? _____ (circle all that apply)
 If the pain is a major component of the primary problem:
 What kind of pain is it? Burning / Throbbing / Achy / Sharp / Dull / Other: _____
 When at rest, rate of pain from 0-10 (0=no pain, 10= worst pain of your life): _____
 What activity (ies) worsen the pain? _____
 What helps to relieve the pain? _____
 When doing these activities, rate the pain 0-10: _____

Date problem started: _____ **Work related?** Yes / No _____ **Car Accident?** Yes / No _____
 Briefly - How did the problem start/occur? _____
 If you were unable to work due to this problem/injury please list dates of disability: From _____ To _____
 Have you had prior imaging study (ies) (ie Xray/MRI) done for this problem? **Yes / No** _____
 If YES, please list type of study(ies), location, and date: _____
 Have you been seen and/or treated by anyone else for this problem/injury? **Yes / No** _____
 If YES, then by whom?: _____ Date(s): _____
 Procedure(s) performed: _____
 Have you had Physical Therapy for this problem? **Yes / No** _____
 If Yes, when and for how long? _____
 Secondary problems/injuries/complaints? _____
 Have you had a cortisone injection for this problem? **Yes / No** If Yes, how many? _____ Last Injection date: _____

Review of Systems

Do you have any problems with, or have you noticed any change in the following areas? If yes, please check which apply to you.

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Anemia | <input type="checkbox"/> Atrophy | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Bloody Sputum | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Burning on Urination |
| <input type="checkbox"/> Breast Masses | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Cough | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Enlarged Lymph Nodes |
| <input type="checkbox"/> Excessive Hunger | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Fever | <input type="checkbox"/> Fracture(s) | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Irregular Heart Beats | <input type="checkbox"/> Malaise | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Pregnancies | <input type="checkbox"/> Seizures | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Skin Rashes | <input type="checkbox"/> Skin Ulcers | <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Strain/Sprain | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Urinary Hesitancy | <input type="checkbox"/> Weakness | <input type="checkbox"/> Weight Gain/Loss | | |

If Yes to any of the above, please explain: _____

If there is anything not listed above, please explain: _____

Medical History

Medical Problems: _____

Are you currently taking any medications (including vitamins and supplements)? **Yes / No**

If Yes, please list: _____

Drug Allergies: PENICILLIN / NOVACAINE / CODEINE / ASPIRIN / TAPE / IODINE / OTHER: _____

Other Allergies: (Including shellfish, latex, IV dye, etc): _____

Previous Surgery (ies) (please give dates if possible): _____

List relationship to you of family members who have had:

Diabetes _____ Foot Problems _____

Arthritis _____ Heart Attack _____

Stroke _____ High Blood Pressure _____

Cancer _____ Birth Defects _____

Social History

Are you currently working? Yes / No Occupation: _____

What hobbies do you participate in? _____

Do you drink alcoholic beverages? Yes / No If yes, how much? _____/per day/week

Do you smoke? Yes / No If Yes, how much? _____/packs per day/week

How many years? _____ If you stopped, when did you do so? _____

Do you use any recreational drugs? Yes / No If Yes, what type and how often? _____

Are you or could you be pregnant? Yes / No Last Menstrual Period _____

Would you like us to send a letter to your PCP concerning your evaluation and treatment today? **Yes / No**

Signature of Patient/Guardian: X _____ Date _____

Doctor has reviewed this form: X _____ Date _____

(For Doctor Use Only)



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AUTHORIZATION FOR PAYMENT

I hereby authorize payment of Medicare or Other Insurance benefit made to my physician for any services furnished to me by that physician. I authorize any holder of medical information about me to release any and all information needed to determine these benefits payable for related services. Furthermore, I understand and agree that I am ultimately responsible (regardless of my insurance status) for the balance on my account for any professional services rendered and that possessing the above insurance information is not a guarantee of coverage.

I have read all of the information on this form and answered all questions to the best of my knowledge. I will notify this office of any changes in my health status or changes in the information provided.

Patient Name or Authorized Representative (If Applicable)

Signature of Patient or Authorized Representative

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if so I so chose) and understood the Notice.

Patient Name or Authorized Representative (If Applicable)

Signature of Patient or Authorized Representative

Date

MANAGED CARE INSURANCE PLANS

If you have a Managed Care type of insurance that requires a referral for each office visit, it is your responsibility to obtain this before your visit. If you have not received the proper authorization, you will either not be seen or you will be responsible for the entire fee.

I have read and understand the Office Policies regarding Managed Care Insurance Plans.

Patient Name or Authorized Representative (If Applicable)

Signature of Patient or Authorized Representative

Date