



Welcome to Our Practice

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____ First Name _____ Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____ Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/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 (____) _____ Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____

Home Phone (____) _____ Cell Phone (____) _____

Work Phone (____) _____ Ext _____

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 assign directly to Dr. _____
 all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not 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 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 Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or 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 or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative

Please print name of Beneficiary, Guardian or 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 complaints.)

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 indicate 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

Ingrown Toenails Yes No

Plantar Warts Yes No

Swelling in Ankles or Feet Yes No

Tired Feet Yes No

MEDICAL HISTORY All information is strictly confidential.

Check (✓) symptoms you currently have or have had in the past year.

- GENERAL**
- Chills
 - Depression/Nervousness
 - Dizziness/Fainting
 - Fever
 - Forgetfulness
 - Headache
 - Loss of sleep
 - Loss of weight
 - Numbness
 - Sweats

- GASTROINTESTINAL**
- Appetite poor
 - Bloating
 - Bowel changes
 - Constipation
 - Diarrhea
 - Excessive thirst
 - Gas
 - Hemorrhoids
 - Indigestion
 - Nausea
 - Rectal bleeding
 - Stomach pain
 - Vomiting
 - Vomiting blood

- EYE, EAR, NOSE, THROAT**
- Bleeding gums
 - Blurred vision
 - Crossed eyes
 - Difficulty swallowing
 - Double vision
 - Earache/Ear discharge
 - Hay fever
 - Hoarseness
 - Loss of hearing
 - Nosebleeds
 - Persistent cough
 - Ringing in ears
 - Sinus problems
 - Vision – Flashes/Halos

- MEN only**
- Erection difficulties
 - Lump in testicles
 - Penis discharge
 - Sore on penis
 - Other _____

- WOMEN only**
- Abnormal Pap Smear
 - Bleeding between periods
 - Breast lump
 - Extreme menstrual pain
 - Hot flashes
 - Nipple discharge
 - Painful intercourse
 - Vaginal discharge
 - Other _____

- MUSCLE/JOINT/BONE**
Pain, weakness, numbness in:
- Arms
 - Back
 - Feet
 - Hands
 - Hips
 - Legs
 - Neck
 - Shoulders

- CARDIOVASCULAR**
- Chest pain
 - High/Low blood pressure
 - Irregular/Rapid heart beat
 - Poor circulation
 - Swelling of ankles
 - Varicose veins

- SKIN**
- Bruise easily
 - Hives
 - Itching/Rash
 - Change in moles
 - Scars
 - Sore that won't heal

Date of last menstrual period _____
 Date of last Pap Smear _____
 Have you had a mammogram? _____
 Are you pregnant? _____
 Number of children _____

- GENITO-URINARY**
- Blood in urine
 - Frequent urination
 - Lack of bladder control
 - Painful urination

Check (✓) conditions you have or have had in the past.

- AIDS
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Cancer
- Cataracts
- Chemical Dependency

- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Heart Disease
- Hepatitis
- Herpes
- High Cholesterol

- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia

- Polio
- Prostate Problem
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers
- Venereal Disease

Describe serious illnesses or operations _____

MEDICATIONS/ALLERGIES

List medications you are currently taking _____

Pharmacy Name _____

Phone (____) _____

List allergies to medications or substances _____

HEALTH HABITS

Check (✓) which you use and how much:

Check (✓) if your work exposes you to:

Caffeine _____

Stress

Street Drugs _____

Heavy Lifting

Tobacco _____

Hazardous Substances

Other _____

Other _____

Your occupation _____

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Reviewed By

Date