WELCOME

PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

Sex: ☐ M ☐ F Age____ Birthdate_____

Marital Status: ☐ Single ☐ Married ☐ Widowed

☐ Separated ☐ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

PHONE NUMBERS

Home_____Work_____Ext_____

Cell _____

IN CASE OF EMERGENCY, CONTACT:

Name_____Relationship_____

Home 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 Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____

Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr._____for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deducltible are based upon the charge determination of the Medicare carrier.

_____

Beneficiary Signature Date

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

Alcohol Use
☐ Social ☐ Moderate ☐ Excessive

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

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

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

If yes, please explain _____

WOMEN ONLY. Are you pregnant? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No _____

MEDICATIONS

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 _____

FINANCIAL AGREEMENT AND CONSENT

INSURANCE AGREEMENT: I acknowledge that I am ultimately responsible for any deductible, co-pay or services not covered by my insurance.

LATE CHARGES: I acknowledge on accounts with balances over 30 days, my monthly finance charge is .834% (annual percentage rate 10%). My monthly cost of rebilling and accounts maintenance charge is $8.00. In the case of default in payment of the account, I agree to pay collection costs and reasonable attorney fees incurred to collect any outstanding balances.

MISSED OR BROKEN APPOINTMENTS: An office visit charge will be assessed on any missed or broken appointments with less than two (2) hours prior notice.

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature _____ Date _____