

Patient Information Sheet

Welcome to our Office...

Please PRINT and fill out this form COMPLETELY, write N/A where applicable and sign it. Thank you.

Social Security#			
First Name:		Last Name:	
Middle Initial:		Date of Birth:	/ /
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other
Street Address:		City:	
State:	Zip:	Employer Name:	
Home Phone:	()	Emergency Contact:	
Work Phone:	()	Emergency Telephone#:	
Cell Phone:	()	Primary Care Physician:	
Reason for today's Visit:		Who referred you to our office:	

Patient's Insurance Information

Primary Insurance Company Information:		Secondary Insurance Company Information:	
Policy Holder Information		Policy Holder Information	
First Name: _____		First Name: _____	
Last Name: _____		Last Name: _____	
Policy Holders SS# _____ - _____ - _____		Policy Holders SS# _____ - _____ - _____	
Policy Holders Date of Birth: _____		Policy Holders Date of Birth: _____	
Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Relationship Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address: _____		Address: _____	
City: _____ State: _____ Zip: _____		City: _____ State: _____ Zip: _____	
Insurance's Name: _____		Insurance's Name: _____	
Policy ID: _____		Policy ID: _____	
Group# _____		Group# _____	
Address: _____		Address: _____	
Effective Date: _____		Effective Date: _____	
Do you have a Co-pay? <input checked="" type="checkbox"/> Yes Amt \$ _____ or <input type="checkbox"/> NO		Do you have a Co-pay? <input checked="" type="checkbox"/> Yes Amt \$ _____ or <input type="checkbox"/> NO	
Referral Required: YES NO		Referral Required: YES NO	

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT IT IS AS A COURTESY THAT THE DOCTOR ACCEPTS MY INSURANCE FOR PAYMENT AND THAT IF FOR ANY REASON THEY DO NOT PAY MY BILL THAT I AM RESPONSIBLE.

I have received the Confidentially Agreement (HIPAA) and agree to comply with all its terms.

Today's Date: _____ Patient's Signature: _____

PODIATRY HISTORY

What is the chief complaint for which you came to be treated?
(Include foot, ankle, knee, thigh, and hi 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 problem you now have or have had in the past.

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

Surgeries you have had _____

Hospitalization other than for the surgeries listed _____

Family Physician _____ Last Visit Date _____

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

If yes, please explain _____

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
- Apirin
- Demerol
- Iodine
- Other: _____
- Local Anesthetics
- Novovaine
- Seafoods
- Sulfa

I hereby consent and give my permission to the doctor (and the doctor's assistants 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