Patient Information Sheet

Social Security#:

First Name: ________________ **Last Name:** ________________ **Middle Initial:** ________

Date of Birth: (MM/DD/YYYY) ______ / ______ / ________ **Age:** ________ **Gender:** ☐Male ☐ Female **Marital Status:** ☐Single ☐Married ☐Widowed ☐Divorced ☐Other

E-Mail Address: ________________ **Would you like to receive emails? Yes No**

Mailing Address: ________________ **Apt.#:** ______ **City:** ________________ **State:** ______ **Zip:** ________

Cell Phone: (_____)________________ **Home Phone:** (____)________________ **Work Phone:** (_____)________________

Employer Name: ________________ **Employer's Address / City / State / Zip** ________________

Emergency Contact: ________________ **Emergency Telephone #:** (____)________________ **Relationship:** ________________

Primary Insurance Company Information:

Policy Holder's First Name & Last Name: ________________

Policy Holder's SSN: ________ - ________ - ________ **Policy Holder's Date of Birth:** ______ / ______ / ______

Gender: ☐Male ☐Female **Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other

Policy Holder's Address: ☐Same as patient ________________

City: ________________ **State:** ________ **Zip:** ________

Insurance's Name: ________________

Policy ID: ________________ **Group #:** ________________

Secondary Insurance Company Information:

Policy Holder's First Name & Last Name: ________________

Policy Holder's SSN: ________ - ________ - ________ **Policy Holder's Date of Birth:** ______ / ______ / ______

Gender: ☐Male ☐Female **Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other

Policy Holder's Address: ☐Same as patient ________________

City: ________________ **State:** ________ **Zip:** ________

Insurance's Name: ________________

Policy ID: ________________ **Group #:** ________________

Family Physician : ________________________________

Pharmacy: ________________________________

How did you hear about us? ________________________________

____

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.

Payments: **Patients are responsible for all fees including missed visits and returned checks. Interest and late fees may apply on past due balances. Payment is expected at the time services are rendered. Payments must be arranged before treatment.**

☐ 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 concern for which you came to be treated?

____

When did you notice the problem? ___________________________
Any other concerns? ____

____

Have you ever been to a Podiatrist before? ☐Yes ☐No
If yes, please list: _________________________________

Is there any personal or family history of diabetes? ☐Yes ☐No

Your occupation ____________________________________
Activities in which you participate (frequency):

____

____

Please indicate which foot problem(s) you now have or have had:

Problem		
Ankle Pain	☐Yes	☐No
Athlete's Foot	☐Yes	☐No
Corns and Calluses	☐Yes	☐No
Cramps or Numbness in Feet or Legs ...	☐Yes	☐No
Arch Problems	☐Yes	☐No
Foot or Leg Cramps	☐Yes	☐No
Gout	☐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

What makes it better?

____

____

Medical History

Condition		Condition		Condition	
AIDS/HIV	☐Yes☐No	Circulatory Problems	☐Yes☐No	Phlebitis	☐Yes☐No
Allergies to Anesthetics	☐Yes☐No	Diabetes Type 1/Type 2	☐Yes☐No	Psychiatric Care	☐Yes☐No
Allergies to Medicine or Drugs **(PLEASE LIST BELOW)**	☐Yes☐No	Ear Problem	☐Yes☐No	Radiation Treatment	☐Yes☐No
Allergies to Latex	☐Yes☐No	Epilepsy	☐Yes☐No	Rash	☐Yes☐No
Allergies to Penicillin	☐Yes☐No	Eye Problem	☐Yes☐No	Respiratory Disease	☐Yes☐No
Anemia	☐Yes☐No	Fainting	☐Yes☐No	Rheumatic Fever	☐Yes☐No
Angina	☐Yes☐No	Headaches	☐Yes☐No	Shortness of Breath	☐Yes☐No
Arthritis	☐Yes☐No	Heart Disease	☐Yes☐No	Sinus Problems	☐Yes☐No
Artificial Heart Valves or Joints	☐Yes☐No	Hemophilia	☐Yes☐No	Special Diet	☐Yes☐No
Asthma	☐Yes☐No	Hepatitis or Jaundice	☐Yes☐No	Stroke	☐Yes☐No
Back Problems	☐Yes☐No	High Blood Pressure	☐Yes☐No	Swollen Neck Glands	☐Yes☐No
Bleeding Disorders	☐Yes☐No	Kidney Problems	☐Yes☐No	Tuberculosis	☐Yes☐No
Cancer: **if so what kind?** ________________________	☐Yes☐No	Liver Disease	☐Yes☐No	Ulcers	☐Yes☐No
Chemical Dependency	☐Yes☐No	Low Blood Pressure	☐Yes☐No	Varicose Veins	☐Yes☐No
Chest Pain	☐Yes☐No	Mental Health Disorders	☐Yes☐No	Venereal Disease	☐Yes☐No
Chronic Diarrhea	☐Yes☐ No	Neuropathy	☐Yes☐No	Alcohol Use How Frequent?	☐Yes☐No ______________
Cigarette/Tobacco Use	☐Yes☐ No	Other (please list):			

Surgeries/Hospitalizations Y / N **If yes, please explain** ____

Family Medical History (please circle)

Diabetes	Cancer	High Blood Pressure	Gout	Arthritis
Heart Disease/Attack	Birth Defects	Foot Problems	Stroke	Other ________________________________

Medications

Include prescriptions, over-the-counter medications and vitamins: ____________

____

____

Allergies

☐Adhesive/Tape	☐Local Anesthetics
☐Anticoagulant Therapy	☐Novocaine
☐Aspirin	☐Seafoods
☐Demerol	☐Sulfa
☐Iodine	☐Codeine
☐Other _______________	☐No Allergies

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to provide podiatric services, and medicines, submit my insurance form, consider my signature "on file" for payment, and to release any & all records needed. I understand the privacy policy, and have read and understand the above and agree to be personally responsible for all charges & fees.

_________________________________ _________________________

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