

Patient Information Sheet

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

Welcome to our Office...

Social Security#		
First Name:	Last Name:	Middle Initial:
Date of Birth: (MM/DD/YYYY) ____/____/____	Age: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
E-Mail Address:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other
Address:	Apt.#: _____	City: _____ State: _____ Zip: _____
Home Phone: (____) _____	Work Phone: (____) _____	Cell Phone: (____) _____
Emergency Contact:	Emergency Telephone#: (____) _____	
Employer Name:	Employer's Address / City / State / Zip	

Referred by:	Referred Person's Address / City / State / Zip	Referring Person's Phone# (____) _____ - _____
Primary Care Physician:	Primary Care Physician's NPI	P.C.P.'s Phone# (____) _____ - _____

<u>PRIMARY</u> Insurance Company Information:	<u>SECONDARY</u> Insurance Company Information:
Policy Holder First Name & Last Name:	Policy First Name & Last Name:
Policy Holders SS# _____ Policy Holders Date of Birth: ____/____/____	Policy Holders SS# _____ Policy Holders Date of Birth: ____/____/____
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Relationship to 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 Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Policy Holder's Address: <input type="checkbox"/> Same as patient	Policy Holder's Address: <input type="checkbox"/> Same as patient
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Insurance's Name:	Insurance's Name:
Policy ID: _____ Group #: _____	Policy ID: _____ Group #: _____
Claim Submission Address:	Claim Submission Address:
Effective Date: ____/____/____	Effective Date: ____/____/____
Do you have a Co-pay? <input type="checkbox"/> No <input type="checkbox"/> Yes, Amt \$ _____	Do you have a Co-pay? <input type="checkbox"/> No <input type="checkbox"/> Yes, Amt \$ _____

Referral Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	Referral Required: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Responsible Party Information – Please complete if the responsible for payment is not the <u>Patient</u> or the <u>Policy Holder</u> .		
Responsible Party's Name (Last / First):	Responsible Party's SSN: _____	Relationship to Responsible Party: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Responsible Party's Address / City / State / Zip:		

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 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:
 Name _____ Last Visit _____
 Is there any personal or family history of diabetes? Yes No
 Your occupation _____
 Activities in which you participate (frequency):

Please indicate which foot problem you now have or have

Ankle Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Athlete's Foot	<input type="checkbox"/> Yes <input type="checkbox"/> No
Corns and Calluses	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cramps or Numbness in Feet or Legs ...	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arch Problems.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Foot or Leg Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heel Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ingrown Toenails	<input type="checkbox"/> Yes <input type="checkbox"/> No
Plantar Warts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling in Ankles or Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tired Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No

What makes it better? _____

 What makes it worse? _____

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	Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Anesthetics	<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
Allergies to Medicine or Drugs	<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
Allergies to Latex	<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 Penicillin	<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
Anemia	<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
Angina	<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
Arthritis	<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
Artificial Heart Valves or Joints	<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
Asthma	<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
Back Problems	<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
Bleeding Disorders	<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
Cancer	<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
Chemical Dependency	<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
Chest Pain	<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
Chronic Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cigarette/Tobacco Use	<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

Surgeries/Hospitalization you have had _____

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) _____

Allergies

<input type="checkbox"/> Adhesive/Tape	<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Anticoagulant Therapy	<input type="checkbox"/> Novocaine
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Seafoods
<input type="checkbox"/> Demerol	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	
<input type="checkbox"/> Other: _____	

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 exceptions must be arranged before treatment.

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 _____