



Welcome

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
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 Phone (_____) _____
Cell Phone (_____) _____
Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____
Home Phone (_____) _____
Work Phone (_____) _____

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/MEDIGAP 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
_____ for any services furnished to me by that provider.
Doctor or Clinic

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 _____

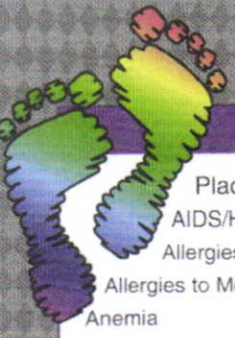
Cigarette/Tobacco use _____

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Athlete's Foot	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bunions	<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
Flat Feet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Foot or Leg Cramps	<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



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 Problems | <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 Problems | <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 Ankles, 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 | Varicose 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 Problems | <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 you 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

- | | |
|--|--|
| <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"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Seafoods |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | |
| Other _____ | |

TREATMENT CONSENT

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

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

Relationship to Patient