

# 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

Occupation \_\_\_\_\_

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 (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT:

Name \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Cell 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'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 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 Doctor or Clinic

for any services furnished to me by that provider.

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) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Family Physician: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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 All information is strictly confidential.

Check (✓) symptoms you currently have or have had in the past year.

### GENERAL

- Chills
- Depression/Nervousness
- Dizziness/Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Numbness
- Sweats

### MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- |                                |                                    |
|--------------------------------|------------------------------------|
| <input type="checkbox"/> Arms  | <input type="checkbox"/> Hips      |
| <input type="checkbox"/> Back  | <input type="checkbox"/> Legs      |
| <input type="checkbox"/> Feet  | <input type="checkbox"/> Neck      |
| <input type="checkbox"/> Hands | <input type="checkbox"/> Shoulders |

### GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

### GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

### CARDIOVASCULAR

- Chest pain
- High/Low blood pressure
- Irregular/Rapid heart beat
- Poor circulation
- Swelling of ankles
- Varicose veins

### EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache/Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision - Flashes/Halos

### SKIN

- Bruise easily
- Hives
- Itching/Rash
- Change in moles
- Scars
- Sore that won't heal

### MEN only

- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other \_\_\_\_\_

### WOMEN only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

Date of last Pap Smear \_\_\_\_\_

Have you had a mammogram? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_

Number of children \_\_\_\_\_

Check (✓) conditions you have or have had in the past.

- AIDS
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Cancer
- Cataracts
- Chemical Dependency

- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Heart Disease
- Hepatitis
- Herpes
- High Cholesterol

- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia

- Polio
- Prostate Problem
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers
- Venereal Disease

Describe serious illnesses or operations \_\_\_\_\_

## MEDICATIONS/ALLERGIES

List medications you are currently taking \_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

List allergies to medications or substances \_\_\_\_\_

## HEALTH HABITS

Check (✓) which you use and how much:

- Caffeine \_\_\_\_\_
- Street Drugs \_\_\_\_\_
- Tobacco \_\_\_\_\_
- Other \_\_\_\_\_

Check (✓) if your work exposes you to:

- Stress
- Heavy Lifting
- Hazardous Substances
- Other \_\_\_\_\_

Your occupation \_\_\_\_\_

## SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Reviewed By

\_\_\_\_\_  
Date