

Welcome to Our Office!

Patient Name: _____ Date: _____
Information Address: _____ City: _____ State: _____
Zip: _____ Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____
Sex: M F Date of Birth: _____ Age: _____ Marital Status: S M D W
Driver's License No: _____ Social Security No: _____

Employer Employer: _____ Work No: _____
Employer Address: _____ Occupation: _____

Spouse/ Name: _____ Employer: _____

Guarantor Employer Address: _____ Occupation: _____

Information SSN: _____ Date of Birth: _____ Occupation: _____
Driver's License No: _____

Referral _____ Doctor _____ Friend _____ Other
Name: _____
Address: _____

Insurance Information

Group Insurance Coverage:

Primary Carrier

Insured: _____
Insurance Co: _____
Group: _____ ID: _____
Phone no. to verify: _____
Medicare No: _____

Other Carrier (Our office does not file secondary ins.)

Insured: _____
Insurance Co: _____
Group: _____ ID: _____
Phone no. to verify: _____
Effective Date: _____

Our Goals

We are dedicated to helping your feet last a lifetime with as little or no pain as possible on a permanent basis. It is important that you answer all questions as thoroughly as you can.

ALL CHARGES INCURRED ARE DUE AND PAYABLE AT THE TIME OF THE VISIT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

I hereby give my permission for the doctor to render the proposed Podiatric examination and treatment. I understand that I am financially responsible to the Physician for all charges incurred by me or my dependents, and further, I authorize the release of any medical information necessary to process any claim and request payment of insurance benefits due to be paid to the Physician supplying the service.

Signature: _____ Date: _____

Patient Clinical Information

Please indicate any of the following that pertain to your medical history.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Kidney disorders | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Lung disorders |
| <input type="checkbox"/> Liver disorders | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Tested positive HIV | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stroke | <input type="checkbox"/> Ankle swelling |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Difficulty in healing |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Pregnant |

Do you have any disease, condition, or problem not listed above that you think we should know about?

Have you ever experienced any adverse side effects or ALLERGIES to:

- | | | | |
|--|---|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Novacaine | <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Cortisone |
| <input type="checkbox"/> Other antibiotics | <input type="checkbox"/> Tape | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Anti-inflammatory medication | | |
| <input type="checkbox"/> No known drug allergies | | | |

Other medication allergies : _____

Name/Address Family Physician: _____

Presently under a physician's care? Yes No Reason: _____

Physician last seen Month: _____ Year: _____

Medications presently taking: _____

In Emergency Contact: (Other than spouse if possible)

Name: _____ Relationship: _____

Address: _____ Phone: (____) _____

Foot Health Information

What is your foot problem? _____

When did it begin? _____

How have you treated your problem so far? _____

Have you seen another doctor for this problem? Yes No If so, who? _____

Have you ever seen a foot doctor before? Yes No If so, who? _____

Was this problem caused by an accident? Yes No If so, when? _____

Was this a work related injury? Yes No If so, where? _____

Shoe size: _____ Height: _____ Weight: _____