

PLEASE PRINT

Date \_\_\_\_\_

Referred By \_\_\_\_\_

**PATIENT INFORMATION**

Patient's Name \_\_\_\_\_

Mailing Address \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Residence Address \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex M F Marital Status \_\_\_\_\_

Name of Family Doctor \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Doctor's Address/Phone # \_\_\_\_\_

Name of Patient Employer \_\_\_\_\_ Phone \_\_\_\_\_

Employer Address \_\_\_\_\_

Person Responsible for Bill \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Name of Spouse (or Parent if a minor child) \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Spouse or Parent Employer \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

In Case of Emergency – Contact \_\_\_\_\_ Phone \_\_\_\_\_

**INSURANCE INFORMATION**

Name of Insurance #1 \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Certificate # \_\_\_\_\_ Group # \_\_\_\_\_ Plan \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Employer \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Insurance #2 \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Certificate # \_\_\_\_\_ Group # \_\_\_\_\_ Plan \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Employer \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Does your insurance have a large deductible?  Yes  No

# MEDICAL HISTORY

CHIEF FOOT COMPLAINT: \_\_\_\_\_

ALLERGIES TO MEDICATION: \_\_\_\_\_

MEDICATIONS BEING TAKEN: \_\_\_\_\_

PREVIOUS SURGERY: \_\_\_\_\_

DO YOU SMOKE: YES  NO  ARE YOU PREGNANT: YES  NO

ANY FAMILY HISTORY OF: HIGH BLOOD PRESSURE  CANCER  STROKE

DIABETES  HEART PROBLEMS

HAVE YOU EVER HAD OR DO YOU PRESENTLY HAVE ANY OF THE FOLLOWING:

ANEMIA .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	HIGH BLOOD PRESSURE .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
ANGINA .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	KIDNEY DISEASE .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
ARTHRITIS .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	PACEMAKER .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
ARTIFICIAL JOINT .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	PHLEBITIS .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
ASTHMA .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	PROLONGED BLEEDING .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
BLADDER PROBLEM .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	PSYCHIATRIC CARE .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
CANCER .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	RHEUMATIC FEVER .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
CHEST PAIN .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	SCARLET FEVER .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
DIABETES .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	STROKE .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
EMPHYSEMA .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	SUGAR IN URINE .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
EPILEPSY OR SEIZURE .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	SWOLLEN ANKLES .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
GLAUCOMA .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	THYROID DISEASE .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
GOUT .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	TUBERCULOSIS .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
HEART ATTACK .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	ULCER .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
HEPATITIS / LIVER DISEASE	YES <input type="checkbox"/>	NO <input type="checkbox"/>			

ANY CONDITION NOT MENTIONED HERE \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ SHOE SIZE \_\_\_\_\_ PHARMACY \_\_\_\_\_

**CREDIT POLICY:** Our office is not responsible for collecting **private insurance claims** and it is expected that patients pay their account in full within 30 days from the date invoiced, even though insurance claims may be pending.

Preferred Method of Payment: Cash \_\_\_\_\_ Check \_\_\_\_\_ Credit Card (MC/Visa) \_\_\_\_\_

**AUTHORIZATION:** I hereby authorize the release to Affiliates in Podiatry, PC of any medical, insurance, or other information needed for this service or a related medical claim or condition. I hereby authorize the release of medical information by Affiliates in Podiatry, PC relating to services necessary, in order to assist in the processing of my insurance claim. The above authorizations may be conveyed by original signature or photocopy, which shall be as valid as the original.

Signed (Patient or responsible party) \_\_\_\_\_

Date \_\_\_\_\_ Witness \_\_\_\_\_

**THANK YOU FOR FILLING OUT THIS FORM. IT WILL HELP US IN GIVING YOU  
THE BEST PODIATRIC MEDICAL CARE.**