



# 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? \_\_\_\_\_

## 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

## PHONE NUMBERS

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

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

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

### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_

Relationship \_\_\_\_\_

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

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

## 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 |