

Welcome To Our Office

Please Print

PATIENT INFORMATION

Date _____ Home Phone _____
Last Name _____ First Name _____ Middle Initial _____ Sex M F
Street _____ City _____ State _____ Zip _____
Social Security # _____ Driver's License # _____ Age _____ Date of Birth ____/____/____
Marital Status _____ Children? _____ Ages _____
Employer _____ Phone _____ Ext. _____
Street _____ City _____ State _____ Zip _____
Occupation _____ May we call you at work? _____ Work Hours _____

FINANCIALLY RESPONSIBLE PARTY (If different from patient)

Home Phone _____
Last Name _____ First Name _____ Middle Initial _____
Street _____ City _____ State _____ Zip _____
Social Security # _____ Driver's License # _____ Age _____ Date of Birth ____/____/____
Employer _____ Phone _____ Ext. _____
Street _____ City _____ State _____ Zip _____
Occupation _____ May we call you at work? _____ Work Hours _____

INSURANCE INFORMATION (If no card is available to copy)

Primary Insurer _____ Phone # _____ Group # _____
Street(PO Box) _____ City _____ State _____ Zip _____
Insured's name _____ Insured's ID # _____
Secondary Insurer _____ Phone # _____ Group # _____
Street(PO Box) _____ City _____ State _____ Zip _____
Insured's name _____ Insured's ID # _____

SPOUSE'S INFORMATION (If appropriate)

Home Phone _____
Last Name _____ First Name _____ Middle Initial _____
Street _____ City _____ State _____ Zip _____
Social Security # _____ Driver's License # _____ Age _____ Date of Birth ____/____/____
Employer _____ Phone _____ Ext. _____
Street _____ City _____ State _____ Zip _____

IN CASE OF AN EMERGENCY

Who should be notified? _____ Relationship _____ Phone _____

Who may we thank for referring you? _____

Please read and sign below: I directly assign all medical and surgical benefits to the doctor. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that fees for service are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co-insurance.

It is the policy of this office to bill your insurance for reimbursement. However, we shall allow no more than sixty (60) days for payment. After sixty (60) days you will be billed for any outstanding balance on your account. All outstanding balances are due thirty (30) days from the statement date.

I HEREBY GIVE AUTHORIZATION FOR TREATMENT.

SIGNED _____

DATE _____

2 PATIENT MEDICAL HISTORY - OVERVIEW

What is your foot problem? _____

When did injury happen or begin? _____

Did this injury occur at work? Yes No If yes, person to authorize treatment? _____ Phone: _____

Describe the accident/event: _____

First visit to a Doctor? Yes No

Previous x-rays? Yes No Where? _____ When? _____

Describe any previous treatment or home remedies? _____

How much are you on your feet at work?
 20% 40% 60% 80% 100%

List the sports/activities: _____

Do you smoke now? Yes No ___ Packs/Day ___ Years

Did you ever smoke? Yes No ___ Packs/Day ___ Years

If you quit, when did you do so? _____

Alcoholic beverages?
 None Rarely Moderately Daily Quit

Drugs? -What kind? _____
 None Rarely Moderately Daily Quit

Have you been treated for: Low back pain
 Broken foot bone(s) Childhood foot problems
 Hammertoes Neuroma
 Ankle injury Knee pain
 High arch feet Bunions
 Ingrown nails Corns
 Arch pain Heel pain
 Flat feet Callouses
 Intoeing Rash

Your Height _____ Weight _____ Shoe Size _____

Do you have or have you ever been treated for:

Diabetes Anemia Blood disease
 Hepatitis Phlebitis Heart trouble
 HIV High Blood Pressure

Are you slow to heal after cuts? Yes No

Any abnormal bruising or bleeding? Yes No

Any pain in calves or buttocks when walking? Yes No

Is the pain relieved by rest? Yes No

Do your feet hurt at night? Yes No

Do you have any difficulty walking? Yes No

Are you taking insulin? Yes No

Are you currently taking any other medications? Yes No

Any allergies, including medication? Yes No

List: _____

Is there a history of skin reaction or other outward reaction of sickness following an injection, oral or topical administration of:

Penicillin or other antibiotics? Yes No Don't Know

Morphine, Codeine, Demerol or other narcotic? Yes No Don't Know

Novocaine or other local anesthetics? Yes No Don't Know

Aspirin, Empirin, other pain remedies? Yes No Don't Know

Sulfa drugs? Yes No Don't Know

Adhesive tape? Yes No Don't Know

Iodine or Merthiolate? Yes No Don't Know

Any other drug, medication or treatment? Yes No Don't Know

If "yes" to any of the above, please explain: _____

Have you had a serious illness? Yes No

Have you ever been hospitalized or been under medical care for very long? Yes No

Have you had any surgery? Yes No

If "yes" to any of the above, please explain: _____

3 PATIENT PHYSICIANS

Family Physician: _____ Date last seen: _____

Phone: _____ Street: _____

City: _____ State: _____ Zip: _____

Did your family Dr. or pediatrician refer you to us? Yes No

Specialist Dr: _____ Specialty _____

Date last seen _____ Phone _____

Street _____ City: _____ State: _____ Zip: _____

Did your specialist Dr. refer you to us? Yes No

Previous Podiatrist: _____ Date last seen: _____

Phone: _____ Street: _____

City: _____ State: _____ Zip: _____

Did your podiatrist refer you to us? Yes No

Did your Dr. send you for consultation? Yes No

Did your Dr. send you for a surgical evaluation? Yes No

Did your Dr. send for a 2nd opinion on surgery? Yes No

Did you independently come for a 2nd opinion? Yes No

4 FAMILY HISTORY

Has any blood relative had:

Tuberculosis? Yes No _____

Cancer or tumor? Yes No _____

High blood pressure? Yes No _____

Heart trouble? Yes No _____

Diabetes? Yes No _____

Birth abnormalities? Yes No _____

Arthritis? Yes No _____

Stroke? Yes No _____

Foot problems? Yes No _____

If "Yes" indicate who _____