PODIATRY ASSOCIATES
FOOT CARE SPECIALISTS
Diplomates, American Board of Podiatric Surgery

Patient's Last Name	First	Middle Initial	Today's Date

Home Address	City	State	Zip	Home Phone No. ( )

Cell Phone No. ( )	Social Security No.	Sex	Birth Date (MO/DAY/YR)	Marital Status	Age

Work Phone No. ( )	Name of Employer	Occupation	Do you have medical insurance ☐ Yes ☐ No

Name of Insurance Co.	Name of Policy Holder (if other than above)	Policy Holder's Date of Birth

Secondary Insurance	Full Name of 2nd Policy Holder	Date of Birth of 2nd Policy Holder

How did you hear about us (other patients, doctors, Yellow Pages, Insurance Company, etc.)?

Name of Family Physician	Phone No.	Date of Last Visit

SPOUSE OR PARENT

Name	Birthdate / /
Social Security #	Home # ( )

Employer	Occupation
Employer's Address	Work # ( )

EMERGENCY CONTACT (MUST HAVE CURRENT PHONE #)

Name _____ Phone # ( )

Relationship to Patient:

Address	City	State	Zip

PATIENT CONSENT FOR RELEASE OF MEDICAL INFORMATION

Dear Patient,

In order to protect your confidentiality and to comply with government regulations (HIPAA), Podiatry Associates is required to obtain authorization from you in order to release messages and/or provide information regarding your care with any person(s) other than yourself.

RELEASE OF MEDICAL INFORMATION:

The physician and staff at Podiatry Associates may discuss my medical information and/or care with the following:
(Example: Relatives, Friends, spouse)

Name _____ Relationship _____ Name _____ Relationship _____

MESSAGES:

I give my consent to the physicians and staff of Podiatry Associates to leave messages or discuss scheduling, treatment, surgery, lab, radiology results or other information regarding my care as follows:

☐ On answering machine or voice mail at home ☐ Cell Phone

☐ On answering machine or voice mail at work ☐ I do not consent to messages being left at home, work or with any other person.

I certify that I have insurance coverage with the company(s) listed in the previous section of this form. I assign directly to Podiatry Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges paid or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature _____ Date _____

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Rash	☐ Yes ☐ No
Allergies to Anesthetics	☐ Yes ☐ No	Eye Problems	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Allergies to Medicine or Drugs	☐ Yes ☐ No	Fainting	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Foot or Leg Cramps	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Artificial Heart Valves or Joints	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Swelling in Ankles, Feet	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis or Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Tired Feet	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Varicose Veins	☐ Yes ☐ No
Chronic Diarrhea	☐ Yes ☐ No	Neuropathy	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Phlebitis	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
Ear Problems	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		

Surgeries you have had _____

Hospitalization other than for the surgeries listed _____

Family physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain _____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

Pharmacy Name(s) _____

Pharmacy Phone(s) (_____)_____

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

☐ Adhesive/Tape	☐ Local Anesthetics
☐ Anticoagulant Therapy	☐ Novocaine
☐ Aspirin	☐ Penicillin
☐ Codeine	☐ Seafoods
☐ Demerol	☐ Sulfa
☐ Iodine	

Other _____

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	☐ 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