PODIATRIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

Patient_____

Address _____

_____

City State Zip

Sex: ___M ___ F Age____ Birthdate_____

Single___ Married__ Widowed__ Separated___ Divorced__

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone _____

Spouse's Name_____

Birthdate_____SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you?

_____

2 INSURANCE

Who is responsible for this account?_____
Relationship to Patient_____
Insurance Co._____
Group #_____
Is patient covered by additional insurance? Yes____ No____
Subscriber Name_____
Birthdate_____SS#_____
Relationship to Patient_____
Insurance Co._____
Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____
Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr._____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____
Beneficiary Signature

3 CONTACT INFORMATION

Email_____

Home_____Work_____Ext____

Mobile_____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Home Phone_____Work Phone_____

4 PODIATRIC HISTORY

What is the chief complaint for which you to be treated (Include foot, ankle, knee hip , thigh complaints)

_____
_____
_____

Have you ever been to a Foot Doctor before? ____ Yes ____ No
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_____ Athlete's Foot_____
Bunions_____ Corns & Callouses___
Cramps or Numbness in Feet or Legs___
Flat Feet _____ Foot or Leg Cramps____
Heel Pain _____ Ingrown Toenails____
Plantar's Warts ____ Tired Feet _____
Swelling in Ankles or Feet _____

5 MEDICAL HISTORY

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

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

Surgeries you have _____
_____
_____

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_____
_____
_____

6 MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins._____
_____
_____
Pharmacy Name(s)_____
Pharmacy Phone(s) _____
Do you take oral contraceptives? ____ Yes ____ No

7 ALLERGIES

__ Adhesive/Tape
__ Anticoagulant Therapy
__ Aspirin
__ Codeine
__ Demerol
__ Iodine
__ Local
__ Novocaine
__ Penicillin
__ Seafoods
__ Sulfa
Other_____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature_____ Date_____