PANHANDLE PODIATRY

(Please Print)

PATIENT INFORMATION

Patient's Last Name:	First:	MI:	Suffix	Marital status (circle one) Single / Mar / Div / Sep / Widow / Partner

Social Security no.:	Birth date: / /	Age:	Sex: ❑ M ❑ F	Mobile Phone ( )	Home phone no.: ( )

Email:	Preferred Method of Communication ❑Text ❑Voice ❑ Email

Street address:	City:	State:	Zip:

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Chose doctor because/referred to doctor by (please check one box): ❑ Dr._____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Name of Primary Insurance ❑ Aetna ❑ Blue Cross Blue Shield ❑Cigna ❑ Humana ❑ PEIA ❑ United Health Care

❑ Medicare ❑ Medicaid _____(plan) ❑ Other _____

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Spouse ❑ Self ❑ Child ❑ Other_____	Co-payment:

Name of secondary insurance (if applicable):	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Additional Insurance:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize PANHANDLE PODIATRY or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

PANHANDLE PODIATRY

PODIATRIC HISTORY

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

_____
_____
_____

Have you ever seen a podiatrist before?
❑ Y ❑ N

If yes, please list:

Name_____

Last Visit_____

Is there any family history of diabetes?

❑ Y ❑ N

Cigarette/Tobacco use

❑ Y ❑ N

Years smoked_____

Athletic Activities in which you participate?
(please list and indicate frequency)

_____
_____

Please indicate current/prior foot problems

Ankle Pain	❑ Y ❑ N
Athlete's Foot	❑ Y ❑ N
Bunions	❑ Y ❑ N
Corns and Calluses	❑ Y ❑ N
Cramps or Numbness in Feet or Legs	❑ Y ❑ N
Flat Feet	❑ Y ❑ N
Heel Pain	❑ Y ❑ N
Ingrown Toenails	❑ Y ❑ N
Plantar Warts	❑ Y ❑ N
Swelling in Feet or Ankles	❑ Y ❑ N

MEDICAL HISTORY

PLEASE MARK YES OR NO IF YOU HAVE OR HAD ANY OF THE FOLLOWING

AIDS/HIV	❑ Y ❑ N	Epilepsy	❑ Y ❑ N	Rash	❑ Y ❑ N
Allergies to Anesthetics	❑ Y ❑ N	Eye Problems	❑ Y ❑ N	Respiratory Disease	❑ Y ❑ N
Allergies to Medicine or Drugs	❑ Y ❑ N	Fainting	❑ Y ❑ N	Rheumatic Fever	❑ Y ❑ N
Anemia	❑ Y ❑ N	Foot or Leg Cramps	❑ Y ❑ N	Shortness of Breath	❑ Y ❑ N
Angina	❑ Y ❑ N	Gout	❑ Y ❑ N	Sinus Problems	❑ Y ❑ N
Arthritis	❑ Y ❑ N	Headaches	❑ Y ❑ N	Special Diet	❑ Y ❑ N
Artificial Hear Valves or Joints	❑ Y ❑ N	Heart Disease	❑ Y ❑ N	Stroke	❑ Y ❑ N
Asthma	❑ Y ❑ N	Hemophilia	❑ Y ❑ N	Swelling in Ankles, Feet	❑ Y ❑ N
Back Problems	❑ Y ❑ N	Hepatitis or Jaundice	❑ Y ❑ N	Swollen Neck Glands	❑ Y ❑ N
Bleeding Disorders	❑ Y ❑ N	High Blood Pressure	❑ Y ❑ N	Tired Feet	❑ Y ❑ N
Cancer	❑ Y ❑ N	Kidney Problems	❑ Y ❑ N	Tuberculosis	❑ Y ❑ N
Chemical Dependency	❑ Y ❑ N	Liver Disease	❑ Y ❑ N	Ulcers	❑ Y ❑ N
Chest pain	❑ Y ❑ N	Low Blood Pressure	❑ Y ❑ N	Varicose Veins	❑ Y ❑ N
Chronic Diarrhea	❑ Y ❑ N	Neuropathy	❑ Y ❑ N	Venereal Disease	❑ Y ❑ N
Circulatory Problems	❑ Y ❑ N	Phlebitis	❑ Y ❑ N	Weight Loss, unexplained	❑ Y ❑ N
Diabetes	❑ Y ❑ N	Psychiatric Care	❑ Y ❑ N		
Ear Problems	❑ Y ❑ N	Radiation Treatment	❑ Y ❑ N		

Surgeries you have had _____
_____
_____

Family Physician_____Last Visit_____

MEDICATIONS

Include any prescription, over the counter medications and vitamins

_____
_____
_____
_____
_____

Preferred Pharmacy_____

ALLERGIES

- ❑ Adhesive Tape
- ❑ Anticoagulant Therapy
- ❑ Aspirin
- ❑ Codeine
- ❑ Demerol
- ❑ Iodine
- ❑ Local Anesthetics
- ❑ Novocain
- ❑ Penicillin
- ❑ Seafood
- ❑ Sulfa
- ❑ Other_____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants) to administer and perform such procedures upon me as the doctors deems necessary

_____ _____
Signature of Patient, Parent/Guardian or Personal Representative Date

_____ _____
Please print name of patient, Parent, Guardian or Person Representative Date