FOOT CLINIC OF WEST BEND
LISA G. KORNELY, DPM
2358 W. WASHINGTON STREET
WEST BEND, WI 53095

PATIENT INFORMATION

Date_____
Last Name_____
First Name_____ __ MI ____
Address_____
City_____
State_____ Zip _____
Sex: □ M □ F Age _____
Birthdate_____
SSN_____
Primary Language_____
Race:
□ White □ American Indian □ Alaska Native □ Asian
□ African American □ Native Hawaiian/Pacific
Ethnicity: _____
Marital Status:
□ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered
Primary Physician _____
Date Last Seen _____
Patient Employer _____
Spouse's Name _____
Spouse's Birthdate_____
Spouse's Employer_____

Whom may we thank for referring you?

_____

INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Company _____
Identification number _____
Subscriber Name _____
Birth date _____

Insurance Assignment & Release

I certify that I have insurance coverage with _____ and assign directly to Dr. Kornely 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.

Dr. Kornely may use my health care information and may disclose such information to the above-named insurance company 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 I inform the office in writing.

_____
Signature of Beneficiary, Guardian, Personal Representative

_____ _____
Date Relationship to Beneficiary

CONTACT INFORMATION

Home Phone (_____)_____
Cell Phone (_____)_____
Work Phone (_____)_____
E-mail _____
Emergency Contact:
Name_____
Relation_____
Home Phone (_____)_____
Cell Phone (_____)_____

PODIATRY HISTORY

What is your chief complaint for which you came to be treated? _____
_____
When did the pain/discomfort begin?
_____
Out of a 10 pain scale (1-least/10-worst), how would you rate your pain? _____
Have you been treated by another physician for this problem? _____

MEDICAL HISTORY

(Check all that *previously* or *currently* apply to you)

□ None
□ AIDS/HIV
□ ALLERGIES TO ANESTHETICS
□ ANEMIA
□ ANGINA
□ ARTHRITIS
□ ASTHMA
□ BACK PROBLEMS
□ BLEEDING DISORDERS
□ CANCER (type:_____)
□ HIGH CHOLESTEROL
□ CIRCULATION PROBLEMS
□ DIABETES
□ EAR PROBLEMS
□ EPILEPSY
□ EYE PROBLEMS
□ GOUT
□ HEADACHES
□ HEMOPHILIA
□ HEPATITIS/JAUNDICE
□ HIGH BLOOD PRESSURE
□ KIDNEY PROBLEMS
□ LIVER DISEASE
□ NEUROPATHY
□ RESPIRATORY PROBLEMS
□ SINUS PROBLEMS
□ SKIN ULCERS
□ STOMACH ULCERS
□ STROKE
□ SWELLING
□ THYROID PROBLEMS
□ VARICOSE VEINS
□ HEART
OTHER:
_____
_____

SURGERIES

(List *all* surgeries you have had)

□ None

_____
_____
_____
_____
_____
_____
_____
_____
_____

HOSPITALIZATIONS

(List hospitalizations other than for surgeries)

_____
_____
_____
_____

MEDICATIONS

(List **all** medications, dosages,& frequency including **over-the-counter medications** and **vitamins**)

□ None

_____
_____
_____
_____
_____
_____

Pharmacy Name: _____
Pharmacy Location:_____

ALLERGIES

(Circle all that apply to you)

□ None

Adhesive tape
Anticoagulant Drugs
Aspirin
Codeine
Demerol
Iodine
Local Anesthetics
Novocaine
Penicillin
Seafood
Sulfa

Other: _____
_____

SOCIAL HISTORY

Smoking Status:

___ Smoker, every day ____Year Started Smoking
___ Smoker, some days
___ Former smoker ____ Year Quit Smoking
___ Never smoked

Alcohol Use: ___never ___occasional ___frequent

Height _____ Weight _____ Shoe Size _____

FAMILY HISTORY

(Check all that apply and **list relation**)

□ Diabetes _____
□ Heart Disease _____
□ Cancer (type) _____
□ High Blood Pressure _____
□ Bleeding disorders _____
□ Circulation Problems _____
□ Other _____
□ None