

PANHANDLE PODIATRY PLLC

(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: <input type="checkbox"/> M <input type="checkbox"/> F	Mobile Phone ()	Home phone no.: ()	
Email:				Preferred Method of Communication <input type="checkbox"/> Text <input type="checkbox"/> Voice <input type="checkbox"/> Email		
Street address:			City:	State:	Zip:	
Occupation:	Employer:	Employer address:			Employer phone no.: ()	
Chose doctor because/referred to doctor by (please check one box):		<input type="checkbox"/> Dr. _____	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital		
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> 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	<input type="checkbox"/> Aetna	<input type="checkbox"/> Blue Cross Blue Shield	<input type="checkbox"/> Cigna	<input type="checkbox"/> Humana	<input type="checkbox"/> PEIA	<input type="checkbox"/> United Health Care
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid _____ (plan)	<input type="checkbox"/> Other _____				
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:		
Patient's relationship to subscriber: <input type="checkbox"/> Spouse <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Other _____					Co-payment:	
Name of secondary insurance (if applicable):			Group no.:	Policy no.:		
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Additional Insurance:						

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
<p>The above information is true to the best of my knowledge and I will update that information with the doctor when information changes. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any unpaid claims and any unpaid balance. I understand that it is my responsibility to verify insurance benefits. I understand that I am responsible for any pre-authorizations for services. I also authorize PANHANDLE PODIATRY PLLC or insurance company to release any information required to process my claims.</p>			
_____ Patient/Guardian signature		_____ Date	

PANHANDLE PODIATRY PLLC

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? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, please list: Name _____ Last Visit _____	Is there any family history of diabetes? <input type="checkbox"/> Y <input type="checkbox"/> N Cigarette/Tobacco use <input type="checkbox"/> Y <input type="checkbox"/> N Years smoked _____ Athletic Activities in which you participate? (please list and indicate frequency) _____ _____ _____	Please indicate current/prior foot problems <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>Ankle Pain</td><td><input type="checkbox"/> Y <input type="checkbox"/> N</td></tr> <tr><td>Athlete's Foot</td><td><input type="checkbox"/> Y <input type="checkbox"/> N</td></tr> <tr><td>Bunions</td><td><input type="checkbox"/> Y <input type="checkbox"/> N</td></tr> <tr><td>Corns and Calluses</td><td><input type="checkbox"/> Y <input type="checkbox"/> N</td></tr> <tr><td>Cramps or Numbness in Feet or Legs</td><td><input type="checkbox"/> Y <input type="checkbox"/> N</td></tr> <tr><td>Flat Feet</td><td><input type="checkbox"/> Y <input type="checkbox"/> N</td></tr> <tr><td>Heel Pain</td><td><input type="checkbox"/> Y <input type="checkbox"/> N</td></tr> <tr><td>Ingrown Toenails</td><td><input type="checkbox"/> Y <input type="checkbox"/> N</td></tr> <tr><td>Plantar Warts</td><td><input type="checkbox"/> Y <input type="checkbox"/> N</td></tr> <tr><td>Swelling in Feet or Ankles</td><td><input type="checkbox"/> Y <input type="checkbox"/> N</td></tr> <tr><td>Other</td><td></td></tr> <tr><td> </td><td></td></tr> <tr><td> </td><td></td></tr> </table>	Ankle Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Athlete's Foot	<input type="checkbox"/> Y <input type="checkbox"/> N	Bunions	<input type="checkbox"/> Y <input type="checkbox"/> N	Corns and Calluses	<input type="checkbox"/> Y <input type="checkbox"/> N	Cramps or Numbness in Feet or Legs	<input type="checkbox"/> Y <input type="checkbox"/> N	Flat Feet	<input type="checkbox"/> Y <input type="checkbox"/> N	Heel Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Ingrown Toenails	<input type="checkbox"/> Y <input type="checkbox"/> N	Plantar Warts	<input type="checkbox"/> Y <input type="checkbox"/> N	Swelling in Feet or Ankles	<input type="checkbox"/> Y <input type="checkbox"/> N	Other					
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Other																												

MEDICAL HISTORY

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

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

Surgeries you have had _____

Family Physician _____ Last Visit _____

MEDICATIONS

Include any prescription, over the counter medications and vitamins

Preferred Pharmacy _____

ALLERGIES

<input type="checkbox"/> Adhesive Tape <input type="checkbox"/> Anticoagulant Therapy <input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> Demerol <input type="checkbox"/> Iodine	<input type="checkbox"/> Local Anesthetics <input type="checkbox"/> Novocain <input type="checkbox"/> Penicillin <input type="checkbox"/> Seafood <input type="checkbox"/> Sulfa <input type="checkbox"/> Other _____
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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 _____