Welcome To Our Practice

Patient Information

How did you find our practice? _____ Today's Date:_____

Patient:_____ Patient's SS# :_____

Address:_____ Marital Status: S - M - D - W - Sep (circle one)

Minor/Dependant

_____ Sex: M / F

City State Zip

Birth Date:_____ Age:_____ Emergency Contact:_____

Phone: Home:_____Cell:_____ Phone: Home:_____ Cell:_____

Work:_____ Work:_____

Best time and place to reach you: _____ Relationship to Patient:_____

Insured's Information

Who will be responsible for payment of deductibles and co-payments? _____

* Please note that in the case of minors and/or divorces, **the parent or guardian requesting care is ALWAYS the responsible party.**

Insured's Name:_____ Insured's SS# :_____

Address:_____ Marital Status: S - M - D - W - Sep (circle one)

_____ Insured's Phone: _____

City State Zip

Birth Date:_____ Age:_____ Sex: M / F

Primary Insurance Co:_____ Relationship to Patient:_____

Secondary Insurance Co:_____ Employer:_____

Authorization for Insurance Payment

I hereby assign payment of insurance benefits directly to Dr. Eric Trattner. I request that payment of authorized Medicare/Insurance benefits be made on my behalf to Dr. Eric Trattner for any and all services provided. I further authorize the release to the Health Care Financing Administration and its agents personal and medical information about me/my child required to determine benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claims.

I also understand that by requesting medical care for myself/my child I am personally responsible for the balance on this account, regardless of insurance coverage, and subject to insurance deductibles and/or co-payments.

_____

Signature

Podiatric History

What is your primary foot problem for which you are

requesting treatment today? _____

_____

Your Occupation_____

Athletic Activities/Frequency:_____

_____

Have you ever seen a Podiatrist before? Y / N

Reasons: _____

Name:_____ Last Visit:_____

Is there a family history of Diabetes? Y / N

Who?_____

Do you use tobacco? Y / N

Height: _____ Weight: _____

Medical History

Please indicate if you have had any of the following:

AIDS/HIV	Y / N	Chronic Diarrhea	Y / N	Hepatitis or Jaundice	Y / N	Special Diet	Y / N
Anemia	Y / N	Circulatory Problems	Y / N	High Blood Pressure	Y / N	Stroke	Y / N
Angina	Y / N	Diabetes	Y / N	Kidney Problems	Y / N	Swelling of Feet or Ankles	Y / N
Arthritis	Y / N	Ear Problems	Y / N	Liver Disease	Y / N		
Artificial Heart Valves or Joints	Y / N	Epilepsy	Y / N	Low Blood Pressure	Y / N	Swollen Neck Glands	Y / N
		Eye Problems	Y / N	Phlebitis or Blood Clots	Y / N		
Asthma	Y / N	Fainting	Y / N	Psychiatric Care	Y / N	Tired Feet	Y / N
Back Problems	Y / N	Foot or Leg Cramps	Y / N	Rashes	Y / N	Tuberculosis	Y / N
Bleeding Disorders	Y / N	Gout	Y / N	Respiratory Disease	Y / N	Ulcers	Y / N
Cancer	Y / N	Headaches	Y / N	Rheumatic Fever	Y / N	Varicose Veins	Y / N
Chemical Dependency	Y / N	Heart Disease	Y / N	Shortness of Breath	Y / N	Venereal Disease	Y / N
Chest Pain	Y / N	Hemophilia	Y / N	Sinus Problems	Y / N	Weight Loss Unexplained	Y / N

Surgeries or hospitalizations:_____

_____

_____

Primary Physician: _____

Physician's Address:_____

Telephone:_____

Date Last Seen:_____

Medications

Please list any medications you take daily. Include any supplements.

_____

_____

_____

_____

_____

Do you take Oral Contraceptives? Y / N

Allergies

List any other allergies to medications, foods or fabrics. Include type of reaction:

Adhesive/Tape	Y / N	Latex	Y / N
Anticoagulant Therapy	Y / N	Local Anesthetics	Y / N
Aspirin	Y / N	Novocain	Y / N
Codeine	Y / N	Penicillin	Y / N
Demerol	Y / N	Seafoods	Y / N
Iodine	Y / N	Sulfa	Y / N

_____

_____

_____

_____

Pharmacy:_____ Address: _____

Phone:_____ _____

Consent for Treatment

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

Patient/Guardian: _____ Date: _____