Podiatric Registration and History

Date: ____/____/________ Social Security: ______-______-_______ Age: _______
Birthdate: ______/______/________ E- Mail: __________________________ @ ___________

Patient Name: ____
Last First MI Sex: Male/ Female

Mailing Address: ____
City State ZIP
Cell: ______-______-_______ Home: ______-______-_______ Preferred Contact: ________
Employer: _______________________________ Occupation: _____________________________
Married/ Widowed/ Single/ Separated/ Divorced/ Minor Student: Y/ N School: __________
Spouse's Name: _____________________ Spouse's Birthdate: _______/ _______/ _________
Spouse's Employer: ____________________ Spouse's Occupation: ________________________
Emergency Contact: ______________________ Phone Number: _______/ _______/ ________

Ethnicity/ Race: American Indian or Alaska Native/ Hispanic or Latino/ Asian/ Black or African American/ Native Hawaiian/ Pacific Islander/ White/ Decline to Answer
Preferred Language: _________________ Sexual Orientation: Straight or Heterosexual/ Lesbian, Gay, or Homosexual/ Bisexual/ Don't Know/ Decline to Answer

Whom may we thank for referring you: ____

Primary Insurance: _______________________ Policy Number: ___________ Group Number: __________
Secondary Insurance: _____________________ Policy Number: ___________ Group Number: __________
Insurance Agreement: I certify that I insurance coverage with _________________ and assign directly to Dr. Mark Lisch 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. The Doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agencies for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my treatment plan is completed or at my request.
Signature: ___________________________________ Date: __________/ __________/ __________

Medicare/ Medigap Authorization

I request that the payment of authorized Medicare benefits, and if applicable, Medigap benefits, be made either to me or on my behalf to Dr. Mark Lisch for any services furnished to me. To the extent permitted by law, I authorize any holder of medical or other information about me to release to The Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

______________________________ ______________________ ___________________ ______________
Signature of Patient/ Guardian Relationship to Patient Print Name Date

Medical History

Place a √ to indicate if YOU have had any of the following

- o AIDS/ HIV
- o Anemia
- o Angina
- o Arthritis
- o Artificial Heart Valves
- o Artificial Joints
- o Back Problems
- o Bleeding Disorders
- o Cancer
- o Chemical Dependency
- o Chest Pain
- o Chronic Diarrhea
- o Circulatory Problems
- o Diabetes
- o Ear Problems
- o Epilepsy
- o Eye Problems
- o Fainting
- o Foot/ Leg Cramps
- o Gout
- o Headaches
- o Heart Disease
- o Hemophilia
- o Hepatitis
- o High Blood Pressure
- o High Cholesterol
- o Kidney Problems
- o Liver Disease
- o Low Blood Pressure
- o Neuropathy
- o Phlebitis
- o Psychiatric Care
- o Radiation Treatment
- o Rash
- o Respiratory Disease
- o Rheumatic Fever
- o Shortness of breath
- o Sinus Problems
- o Special Diet
- o Stroke
- o Swelling in Ankles/ Feet
- o Swollen Neck Glands
- o Tired Feet
- o Tuberculosis
- o Ulcers
- o Varicose Veins
- o Venereal Disease
- o Weight Loss, Unexplained

Pharmacy: ______________________________

Phone Number: _________/ _________/ ___________

Primary Physician: ___________________________

Phone Number: ______________________________

Shoe Size: _______ Height: _______ Weight: ________

Surgeries:

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Hospitalizations other than Surgery:

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Please describe why you are here today:

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Previous Treatments or Doctors you have seen for this problem:

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Treatment Consent: I hereby consent and give my permission to Dr. Mark Lisch to administer and perform procedures upon me as the Doctor deems necessary.

________________________ _____/_____/______

Signature of Patient/ Guardian Date

Medication List

Medication — Strength

- ____________________ - __________
- ____________________ - __________
- ____________________ - __________
- ____________________ - __________
- ____________________ - __________
- ____________________ - __________
- ____________________ - __________
- ____________________ - __________
- ____________________ - __________
- ____________________ - __________
- ____________________ - __________
- ____________________ - __________
- ____________________ - __________
- ____________________ - __________
- ____________________ - __________

ALLERGIES

- o **NONE KNOWN**
- o Aspirin
- o Codeine
- o Iodine
- o Novocain
- o Penicillin
- o Seafood
- o Sulfa
- o Other:

Release of Information

I give permission to Dr. Mark Lisch and Office Staff to release my information to the following. This includes, but not limited to, appointment times and medical information. I can decide to revoke any access at any time.

Name: ____________________
Relationship: ____________________
Phone Number: ____________________

Name: ____________________
Relationship: ____________________
Phone Number: ____________________

Name: ____________________
Relationship: ____________________
Phone Number: ____________________

Name: ____________________
Relationship: ____________________
Phone Number: ____________________

DO NOT RELEASE ANY INFORMATION TO THE FOLLOWING:

Name: ____________________

Name: ____________________

Name: ____________________

I, ____________________, give permission to Dr. Mark Lisch and Office Staff to continue my care with the following choices:

- o Leave a message on my cell/ home phone with detailed information
- o Send text messages/ e-mail
- o Other: ______________________________

Please complete all sections of this packet (3 pages). Return it to our office or bring it with you to your appointment. We will also need to scan your driver's license or ID and ALL insurance cards that you would like us to file. If you don't have your necessary paperwork, please consider rescheduling your appointment or private pay. No pictures or videos are allowed to be taken in the office without permission.