AFFILIATES IN PODIATRY, PC

PLEASE PRINT

Date ________________________________ Referred By ________________________________

PATIENT INFORMATION

Patient's Name ____

Mailing Address ______________________ Town ______________ State ________ Zip __________

Residence Address ______________________ Town ______________ State ________ Zip __________

Home Phone ______________ Business Phone ______________ Cell Phone ______________

SS# ______________ Date of Birth ____________ Age ________ Sex M F Marital Status __________

Name of Family Doctor ______________________________ Date Last Seen ______________________

Doctor's Address/Phone # ____

Name of Patient Employer____ Phone ______________

Employer Address ____

Person Responsible for Bill ____ Phone ______________

Address ____

Name of Spouse (or Parent if a minor child) ______________________________ SS# ______________

Address ____ Phone ______________

Spouse or Parent Employer ____ Phone ______________

Address ____

In Case of Emergency – Contact ____ Phone ______________

INSURANCE INFORMATION

Name of Insurance #1 ____ Phone ______________

Address ____

ID # ______________________ Group # ______________________ Plan ______________________

Subscriber Name ______________________________ Relation to Patient ______________________

Employer ______________________ SS# ______________________ Date of Birth ______________

Name of Insurance #2 ____ Phone ______________

Address ____

ID # ______________________ Group # ______________________ Plan ______________________

Subscriber Name ______________________________ Relation to Patient ______________________

Employer ______________________ SS# ______________________ Date of Birth ______________

Does your insurance have a large deductible? ☐ Yes ☐ No

PLEASE FILL OUT BOTH SIDES COMPLETELY

MEDICAL HISTORY

CHIEF FOOT COMPLAINT: ____________________

ALLERGIES TO MEDICATION: ____________________

MEDICATIONS BEING TAKEN: ____________________

PREVIOUS SURGERY: ____________________

DO YOU SMOKE: YES ☐ NO ☐ ARE YOU PREGNANT: YES ☐ NO ☐

ANY FAMILY HISTORY OF: HIGH BLOOD PRESSURE ☐ CANCER ☐ STROKE ☐

DIABETES ☐ HEART PROBLEMS ☐

HAVE YOU EVER HAD OR DO YOU PRESENTLY HAVE ANY OF THE FOLLOWING:

ANEMIA	YES ☐	NO ☐	HIGH BLOOD PRESSURE	YES ☐	NO ☐
ANGINA	YES ☐	NO ☐	KIDNEY DISEASE	YES ☐	NO ☐
ARTHRITIS	YES ☐	NO ☐	PACEMAKER	YES ☐	NO ☐
ARTIFICIAL JOINT	YES ☐	NO ☐	PHLEBITIS	YES ☐	NO ☐
ASTHMA	YES ☐	NO ☐	PROLONGED BLEEDING	YES ☐	NO ☐
BLADDER PROBLEM	YES ☐	NO ☐	PSYCHIATRIC CARE	YES ☐	NO ☐
CANCER	YES ☐	NO ☐	RHEUMATIC FEVER	YES ☐	NO ☐
CHEST PAIN	YES ☐	NO ☐	SCARLET FEVER	YES ☐	NO ☐
DIABETES	YES ☐	NO ☐	STROKE	YES ☐	NO ☐
EMPHYSEMA	YES ☐	NO ☐	SUGAR IN URINE	YES ☐	NO ☐
EPILEPSY OR SEIZURE	YES ☐	NO ☐	SWOLLEN ANKLES	YES ☐	NO ☐
GLAUCOMA	YES ☐	NO ☐	THYROID DISEASE	YES ☐	NO ☐
GOUT	YES ☐	NO ☐	TUBERCULOSIS	YES ☐	NO ☐
HEART ATTACK	YES ☐	NO ☐	ULCER	YES ☐	NO ☐
HEPATITIS / LIVER DISEASE	YES ☐	NO ☐			

ANY CONDITION NOT MENTIONED HERE ____________________

HEIGHT __________ WEIGHT __________ SHOE SIZE __________ PHARMACY __________

AUTHORIZATION: I hereby authorize the release to Affiliates in Podiatry, PC of any medical, insurance, or other information needed for this service or a related medical claim or condition. I hereby authorize the release of medical information by Affiliates in Podiatry, PC relating to services necessary, in order to assist in the processing of my insurance claim. The above authorizations may be conveyed by original signature or photocopy, which shall be as valid as the original.

Signed (Patient or responsible party) ____________________

Date ____________________ Witness ____________________

THANK YOU FOR FILLING OUT THIS FORM. IT WILL HELP US IN GIVING YOU THE BEST PODIATRIC MEDICAL CARE.