

AFFILIATES IN PODIATRY, PC

PLEASE PRINT

Date _____

Referred By _____

PATIENT INFORMATION

Patient's Name _____ Patient's Email _____

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

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.**