

WELCOME TO OUR OFFICE

Please provide the Following Important Information
(All information is kept private and confidential)

PATIENT NAME _____ SS# _____

PATIENT ADDRESS _____ CITY _____ ST _____ ZIP _____

DATE OF BIRTH _____ AGE _____ SEX: MALE FEMALE (Circle one) MARITAL STATUS: M S W D

HOME PHONE _____ CELL PHONE _____ OTHER _____

NAME OF SPOUSE/PARENT/GUARDIAN _____ PHONE _____

ADDRESS OF SPOUSE/PARENT/GUARDIAN _____ PHONE _____
(If same write "SAME")

NAME OF FAMILY PHYSICIAN _____ PHONE _____

DID YOUR FAMILY PHYSICIAN REFER YOU TO OUR OFFICE? Y N REFERRED FOR: __ 2nd OPINION __ SURGICAL EVALUATION __ CONSULT

NAME OF REFERRING PHYSICIAN: _____ REFERRED FOR: __ 2nd OPINION __ SURGICAL EVALUATION __ CONSULT
(If other than family physician)

NAME OF EMPLOYER/SCHOOL _____ PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ ST _____ ZIP _____

STATUS OF EMPLOYMENT/SCHOOL (Please circle one) FULL TIME PART-TIME RETIRED OTHER OCCUPATION: _____

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE _____ INSURED DATE OF BIRTH _____

NAME OF INSURED _____ SS# _____
(Person who carries insurance)

INSURED ADDRESS _____ CITY _____ ST _____ ZIP _____
(If same write "SAME")

INSURED PHONE _____ RELATIONSHIP TO PATIENT SELF SPOUSE PARENT GUARDIAN

NAME OF EMPLOYER _____ PHONE _____

EMPLOYER ADDRESS _____ CITY _____ ST _____ ZIP _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE _____ INSURED DATE OF BIRTH _____

NAME OF INSURED _____ SS# _____
(Person who carries insurance)

INSURED ADDRESS _____ CITY _____ ST _____ ZIP _____
(If same write "SAME")

INSURED PHONE _____ RELATIONSHIP TO PATIENT SELF SPOUSE PARENT GUARDIAN

NAME OF EMPLOYER _____ PHONE _____

EMPLOYER ADDRESS _____ CITY _____ ST _____ ZIP _____

PATIENT'S HEIGHT: _____

WEIGHT: _____

SHOE SIZE: _____

MEDICAL HISTORY:

HAVE YOU BEEN TREATED FOR/OR DO YOU HAVE: Please check all that apply

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Broken foot bone(s) | <input type="checkbox"/> Corns/Calluses | <input type="checkbox"/> Stroke | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Broken Ankle | <input type="checkbox"/> Bunions | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Ankle Sprain | <input type="checkbox"/> Hammer Toes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Arch Pain | <input type="checkbox"/> Heel Pain | <input type="checkbox"/> Hearing/Ear Problems | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> High Arches | <input type="checkbox"/> Nerve Disorder | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Neuroma | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Leg Cramps/Stiff Joints | <input type="checkbox"/> Numbness in feet | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Gait (Walking) Problems | <input type="checkbox"/> Ingrown Nails | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Childhood Foot Problems | <input type="checkbox"/> Fungus Nails | <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Toe-Walking | <input type="checkbox"/> Athlete's foot | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thick Scar |
| <input type="checkbox"/> Toeing-In | <input type="checkbox"/> Warts | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Flat Feet | <input type="checkbox"/> Leg or Foot Ulcers | <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Severe Ankle Swelling | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mumps |
| | <input type="checkbox"/> Other | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Glaucoma |
| | | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Alzheimer's |
| | | <input type="checkbox"/> Lymes Disease | <input type="checkbox"/> Headaches |
| | | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Sciatica |
| | | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> NONE ABOVE |

PLEASE LIST PAST SURGERIES

TYPE OF SURGERY	DATE OF SURGERY	COMPLICATIONS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING

MEDICATION	DOSAGE	TAKING MEDICATION FOR
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you taking your medications as your doctor prescribed? YES NO
 What Pharmacy do you regularly deal with:
 Pharmacy name: _____ Phone: _____

ALLERGIES: Please check all that apply.

ALLERGY	TYPE OF REACTION
<input type="checkbox"/> Penicillin	_____
<input type="checkbox"/> Other antibiotics	_____
<input type="checkbox"/> Codeine	_____
<input type="checkbox"/> Demerol	_____
<input type="checkbox"/> Phenergan	_____
<input type="checkbox"/> Other Narcotics	_____
<input type="checkbox"/> Novocaine	_____
<input type="checkbox"/> Sulfa Drugs	_____
<input type="checkbox"/> Aspirin	_____
<input type="checkbox"/> Barbiturates	_____
<input type="checkbox"/> Erythromycin	_____
<input type="checkbox"/> Tylenol	_____
<input type="checkbox"/> Advil, Aleve, Motrin	_____
<input type="checkbox"/> Adhesive Tape	_____
<input type="checkbox"/> Shrimp, iodine, Merthiolate	_____
<input type="checkbox"/> Other	_____

FAMILY MEDICAL HISTORY The following questions are regarding immediate family (parents, grandparents, siblings, and children)

ILLNESS	RELATIONSHIP TO PATIENT	ILLNESS	RELATIONSHIP TO PATIENT
<input type="checkbox"/> Heart Problems	_____	<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Heart Attack	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Leg Foot Deformities	_____	<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Nail problems (ingrown/fungus)	_____	<input type="checkbox"/> Diabetes	_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

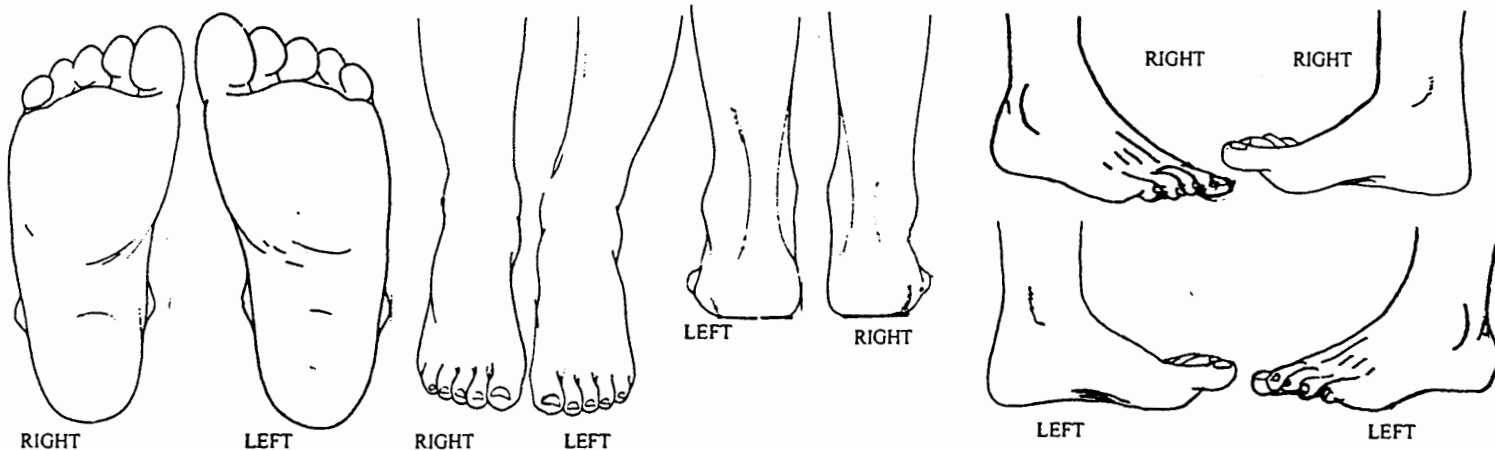
- Do you wear or have you ever worn:

A) Orthotics	YES	NO	Are you still wearing them?	YES	NO	Did they help you?	YES	NO
B) Shoe Inserts	YES	NO	Are you still wearing them?	YES	NO	Did they help you?	YES	NO

 C) Who prescribed the above? _____
- What percentage of your day is spent standing on your feet? 20% 40% 50% 60% 80% 100%
- Do you smoke? YES NO Did you quit? YES NO
 # of packs per day _____ When did you Quit? _____
- Date you last saw your family doctor _____
- Do you drink Alcoholic beverages? YES NO
- Do you take recreational drugs? YES NO

PATIENT'S PRIMARY COMPLAINT:

Please put a #1 on the diagram below to indicate the area of your primary complaint.
Please put a #2 on the diagram below to indicate the area of your secondary complaint.



My primary complaint is on my: right foot left foot both feet

Please describe your primary complaint. _____

What type of pain/discomfort are you having? Shooting pain Throbbing pain Sharp pain Burning pain Aching pain
(Please check all that apply) Dull pain Tenderness Itching Tingling Numbness

How would you rate your pain? None Light Moderate Strong Severe

When did your symptoms start? _____ Do you feel your symptoms are: worsening staying the same better
Is this problem work related? When did injury occur? _____ Date reported to employer: _____

My secondary complaint is on my: right foot left foot both feet

Please describe your secondary complaint. _____

What type of pain/discomfort are you having? Shooting pain Throbbing pain Sharp pain Burning pain Aching pain
(Please check all that apply) Dull pain Tenderness Itching Tingling Numbness

How would you rate your pain? None Light Moderate Strong Severe

When did your symptoms start? _____ Do you feel your symptoms are: worsening staying the same better
Is this problem work related? When did injury occur? _____ Date reported to employer: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

- 1) Are your first steps out of bed painful? Y N ...then subside? Y N
- 2) Do you get leg cramps during the day? Y N ...at night? Y N
- 3) Does foot pain limit your activities? Y N
- 4) Does your foot problem cause any difficulty in walking? Y N
- 5) Any pain in calves or buttocks when walking? Y N
- 6) Is the pain relieved by stopping and standing still? Y N
- 7) Are you slow to heal after cuts? Y N
- 8) Any abnormal bruising, bleeding or scarring? Y N
- 9) Are you currently taking any medications? Y N ... insulin? Y N

- 10) Are you taking vitamins or supplements that contain: garlic Gingko biloba
 echinacea ginseng
 St. John's Wort
- 11) Do you have vascular grafts Y N
- 12) Do you have implants? Y N
- 13) Do you have replacement heart valves? Y N

DOCTORS SIGNATURE: _____ DATE: _____

West Ten Podiatry Centre, Inc.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize West Ten Podiatry Centre, Inc., and any associated physician to release information concerning the medical history and treatment for purposes of insurance claim processing. I have read, understood and accurately answered all questions above and assume responsibility for payment of account (including those fees which are not paid through medical insurance).

SIGNATURE _____ **DATE** _____

AUTHORIZATION FOR PAYMENT

I request that payment of authorized medical insurance benefits be made on my behalf to West Ten Podiatry Centre, Inc. for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the health care financing administration or the involved health insurance company and its agents any information needed to determine these benefits or the benefits payable to related services.

SIGNATURE _____ **DATE** _____

AUTHORIZATION OF TREATMENT FOR A MINOR

I, _____, hereby give the person(s) listed below consent/permission to authorize treatment for my
(Name of parent/guardian)
my minor child _____ from the physicians at West Ten Podiatry Centre, Inc. This permission enables West Ten
(Name of patient)
Podiatry to obtain a history, examine the child, administer anesthesia, and perform procedures.

(Name of person authorized to give consent)

(Relationship to patient)

(Name of person authorized to give consent)

(Relationship to patient)

SIGNATURE _____ **DATE** _____

AUTHORIZATION TO RELEASE PRIVATE/MEDICAL INFORMATION

I authorize West Ten Podiatry to release private/medical information to the following:

(Name of person authorized to receive information)

(Date of birth /relationship to patient)

(Name of person authorized to receive information)

(Date of birth/relationship to patient)

HIPAA PRIVACY NOTIFICATION

West Ten Podiatry Centre, Inc. has provided me with their HIPAA compliant notice of privacy practice policy.

SIGNATURE _____ **DATE** _____