PODIATRY 1st

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First Name: _____ Middle Initial: _____ Last Name _____

Date of Birth: _____ /_____ / _____ Sex: ___ Male ___ Female

Home Address: _____ City _____ State _____ Zip _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

How did you hear about us?

□ Google/Internet Search □ Existing Patient/Friend/Family: _____
(please provide name so we can thank them)

□ Physician Referral: _____ □ Other:_____
(name of physician or clinic that referred you)

Race/Ethnicity (Optional)

Race: □ Caucasian □ African American □ Asian □ Hispanic □ American Indian □ Other □ Prefer Not to Answer

Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ Prefer Not to Answer

Marital Status:

□ Single □ Married □ Divorced □ Widowed

Employment Status:

□ Employed FT □ Employed PT □ Unemployed □ Retired □ Disabled

Patient's Employer: _____ Occupation: _____

Insurance Information

Primary Insurance Co.:_____ Relationship to Patient: _____

Policy Holder Name _____ Policy Holder Date of Birth: _____

Insured Person's Phone #: _____ **Do you have a secondary insurance?** YES NO

What is your preferred pharmacy? _____ Phone Number (if known) _____

Location: Street _____ City _____ Zip _____

Who is your family doctor: _____ Location: _____

Date you last saw your physician: _____ / _____ / _____

Emergency contact information

Name: _____Relation:_____ Phone: _____

Patient Signature _____ **Date** _____

PODIATRY 1st

REQUEST FOR CONFIDENTIAL INFORMATION

I hereby request Podiatry 1st to contact me by: (Please check all that apply)

[ ] Cell Phone May leave message: Yes_____ No_____
[ ] Home Phone May leave message: Yes_____ No_____
[ ] Work Phone May leave message: Yes_____ No_____

I also authorize Podiatry 1st to speak with the following people in regards to my diagnosis and/or treatment options or any other related healthcare issues:

Name:_____ Relationship_____ Phone:_____

Name:_____ Relationship_____ Phone:_____

Name:_____ Relationship_____ Phone:_____

I understand that Podiatry 1st is not required by law to agree to this request but every attempt will be made to abide by my restrictions unless I am in need of emergency treatment. This agreement is valid until revoked by me in writing.

SIGNATURE: _____ DATE: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT GUARANTY OF PAYMENT OF MEDICAL SERVICES

I hereby authorize Podiatry 1st to furnish information to insurance carriers, other physicians and any other facilities involving the treatment/care of illness/injuries and for services provided as a patient of Podiatry 1st. I also hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I authorize payment of benefits to the physician or supplier. I understand that I am financially responsible for all medical and related charges incurred by me and/or my dependent in my/his/her medical treatment provided by my physician or other persons or facilities acting with or in the place of my physician, whether or not such charges are covered by insurance, including any and all collection fees, costs and attorney fees incurred by the physician or facility in collecting my or my dependent's medical bill. This authorization applies to all occasions of service until it is revoked by me in writing. I also hereby authorize photocopies of this authorization form to be as valid as the original.

SIGNATURE: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES / PATIENT RIGHTS AND RESPONSIBILITIES ACKNOWLEDGMENT

I acknowledge that I am aware of Podiatry 1st's Notice of Privacy Practices and consent to the use of disclosure of my Protected Health Information (PHI) by Podiatry 1st for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, to conduct health care operations of Podiatry 1st and as required by law.
I also acknowledge that I was offered the entire notice and that I understand I may obtain a full version of the notice at any time. I understand my rights as a patient of this practice concerning my PHI, as it is outline in this notice and in addition I have received a copy of Podiatry 1st's Patient Rights and Responsibilities. I am aware that Podiatry 1st reserves the right to change the privacy practices that are described in this Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by contacting the office.

SIGNATURE: _____ DATE: _____

Date: _____

Patient name: _____

PODIATRY 1st

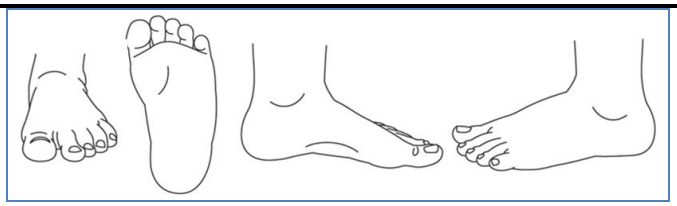
Reason for your visit today

Please describe the issue(s) / concern(s) that brings you to our office today?

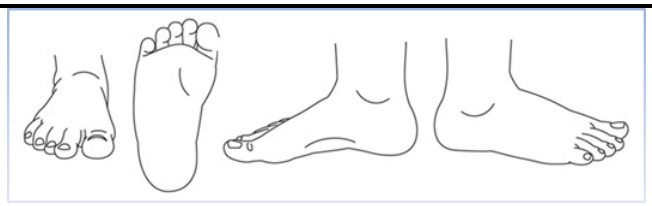
_____

_____

Where is the pain/problem located? ***Please MARK on the pictures below.***



Left Foot



Right Foot

How long ago did this problem start? _____

Onset of condition: ☐ Suddenly ☐ Gradually

Is there any known injury related to the condition? ☐ No ☐ Yes (Date of Injury:_____)

Did you sustain an injury at work? Yes No

Are your injuries auto accident related? Yes No

Briefly describe details of injury: _____

Describe your pain? ☐ No Pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Electrical

☐ Other: _____

How would you rate your pain on a scale from 0 to 10? (please circle)

No Pain* = 0** 1 2 3 4 5 6 7 8 9 **10 = *Worst Pain Imaginable

Since your pain or problem(s) began, has it: ☐ Worsened ☐ Improved ☐ Unchanged

What tends to worsen the condition or pain? ☐ Shoes ☐ Not wearing shoes ☐ Dress shoes / heels

☐ Prolonged standing / walking ☐ Running ☐ Other: _____

What seems to improve or make your condition feel better?

☐ Not wearing shoes ☐ Wearing shoes ☐ Getting off feet ☐ Elevating feet

☐ Other: _____

What treatments have you had / tried for this problem? ☐ None ☐ Injections

☐ Medication _____ ☐ Other: _____

How has this problem affected your lifestyle or ability to work? ☐ It has not affected me

☐ Reduced physical activity ☐ Unable to work ☐ Depression

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Medications

Please list all current prescriptions, over the counter medications, and herbal or dietary supplements.

□ **No Current Prescription Medications, over the counter Medicines, or herbal or dietary supplements**

□ **Please see attached list, or**

Medication Name: _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Past Medical History

□ **No Past Medical History or Conditions**

- ☐ Atrial Fibrillation (A-fib)
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ **Blood Clot** (DVT)
- ☐ **Cancer**
  type: _____
- ☐ Coronary Artery Dis. (CAD)
- ☐ Depression
- ☐ **Diabetes**
  - **Age when diagnosed:** _____
  - **Last A1C (if known):** _____
- ☐ GERD/Reflux
- ☐ **Gout**
- ☐ HIV or AIDS
- ☐ Heart Attack (MI)
- ☐ Heart Failure (CHF)
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Cholesterol
- ☐ High blood pressure
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ Lung Disease
- ☐ Migraines
- ☐ **Neuropathy of feet**
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ **PAD**
- ☐ Pneumonia
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Rheumatoid Arthritis
- ☐ Seizures/Epilepsy
- ☐ Stroke (CVA / TIA)
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Vein problems
- ☐ **Wounds** (nonhealing leg / foot)
- ☐ Other: _____

Allergies

□ **NO Allergies or adverse reactions**

- □ Penicillin
- □ Ciprofloxacin
- □ Erythromycin
- □ NSAIDS
- □ Other Allergies: _____
- □ Sulfa
- □ Keflex
- □ Aspirin
- □ Adhesive Tape
- □ Codeine
- □ Vicodin
- □ Contract dye
- □ Morphine
- □ Iodine
- □ Latex
- □ Anesthetics
  (□ Local □ General)

Prior Foot / Ankle Surgery

□ **NO Prior Foot or Ankle Surgeries**

□ **YES** (List procedure and year performed) _____

_____

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Family Medical History *(mother, father, siblings):*

□ **NO Family Medical History**

□ Diabetes □ Blood Clots or Bleeding Disorders □ Psoriasis

□ Rheumatoid Arthritis □ Cancer (type: _____) □ Other_____

Social History

Tobacco: □ Never smoke □ Quit: How Long Ago? _____

□ Current smoker ⇒ #_____ packs/day for _____years

Recreational Drugs: □ Never □ Occasional □ Weekly □ Daily

□ Marijuana □ Meth □ Cocaine □ Other _____

Alcohol Use: □ Never □ Social □ Daily □ Approx Drinks/Week_____

Exercise: □ Sedentary □ Moderate □ Active

Living With: □ Alone □ Spouse □ Partner □ Family □ Friends

Occupation: Current or former Position Held: _____

Status: □ work FT □ work PT □ Retired □ Unemployed.

□ Disabled: due to what medical condition? _____

Systems Review

(check any symptoms below experienced in past 1-2 months)

☐ **None**

General	☐ Nausea, fever chills	☐ Unexplained loss or gain of weight
	☐ Unexplained fatigue / lack of energy	☐ Recent fall
Peripheral Vascular	☐ fatigue in calf muscle with walking	☐ pain, swelling or feeling of tightness in leg
	☐ toes turn blue, painful with cold weather	☐ frequent or chronic swelling of legs
Neurological	☐ dizziness, light headed or fainting	☐ difficulty with balance
	☐ weakness or paralysis	
Peripheral Neurological	☐ burning, tingling, stinging of feet	☐ weakness of foot / feet
	☐ numbness of foot /feet	
Gastro-intestinal	☐ abdominal pain	☐ frequent heartburn
	☐ bloody stool	☐ frequent nausea or vomiting
Skin	☐ excessive sweating of feet or hands	☐ non healing skin lesions
	☐ chronic or recurrent skin rash	☐ tendency to form thick scars (keloids)
Musculo-skeletal	☐ low back pain	☐ knee pain
	☐ hip pain	☐ swelling / stiffness - joints of hands or feet
Endocrine	☐ delayed healing of wounds	☐ excessive thirst
	☐ intolerance to cold or heat	☐ frequent urination
Hematology / oncology	☐ anemia	☐ bleed or bruise easily
	☐ anticoagulant use	

_____ _____

Patient Signature **Date**