

Welcome to the Community Podiatry Group, P.C.

PATIENT INFORMATION

Today's Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Social Security #: _____

Sex: Male Female

Marital Status: Single Married Widowed
 Divorced Separated

Parent's Name(s) if patient is a minor _____

Occupation: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Are you disabled? Yes No; Why? _____

CONTACT INFORMATION

Please place a check next to the best number to contact you regarding appointments or test results

Home Phone #: _____

Work Phone #: _____ Ext: _____

Cell Phone #: _____

Other/Email (explain) _____

May we leave a message on your answering machine or with someone else in your household? Yes No

In Case of Emergency, Contact:

Name: _____

Relationship: _____

Home Phone #: _____

Work Phone #: _____ Ext: _____

If there is anyone (such as a spouse or caregiver) assisting in your care or treatment to whom you approve releasing your medical information, please list here:

Name Relationship

Name Relationship

INSURANCE INFORMATION

Who is responsible for this account? _____

Name of Health Insurance Co: _____

Subscriber Name: _____

Relationship: _____ Subscriber Birth Date: _____

Contract # _____ Social Security # _____

Second Health Insurance Co: _____

Subscriber Name: _____

Relationship: _____ Subscriber Birth Date: _____

Contract # _____ Social Security # _____

Do you have additional insurance? Yes No

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance with _____ and assign directly to the **Community Podiatry Group, P.C.** all insurance benefits, it 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature

Date

Relationship

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the **Community Podiatry Group, P.C.** for any services provided to me by this office and/or physicians in this office. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medication information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I, the undersigned, acknowledge receipt of the Notice of Privacy Practices.

_____/_____
(Signature, patient or patient representative) (Date)

If Personal Representative's signature appears above, please describe Personal Representative's relationship to patient.

*to be filed and retained for a minimum of six (6) years

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you now have or previously had any of the following conditions:

AIDS/HIV	Yes	No	Diabetes	Yes	No	Psychiatric Clinic	Yes	No
Allergies to Drugs	Yes	No	Ear Problems	Yes	No	Radiation Treatment	Yes	No
Anemia	Yes	No	Epilepsy/Seizures	Yes	No	Rash	Yes	No
Angina	Yes	No	Eye Problems	Yes	No	Respiratory Disease	Yes	No
Arthritis	Yes	No	Fainting	Yes	No	Rheumatic Fever	Yes	No
Artificial Heart Valves	Yes	No	Foot Ulcer/Sore	Yes	No	Shortness of Breath	Yes	No
Artificial Joints	Yes	No	Gout	Yes	No	Sinus Problems	Yes	No
Asthma	Yes	No	Headaches	Yes	No	Stroke	Yes	No
Back Problems	Yes	No	Heart Problems/Disease	Yes	No	Swelling in Ankles/Feet	Yes	No
Bleeding Disorders	Yes	No	Hemophilia	Yes	No	Swollen Neck Glands	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No	Tuberculosis	Yes	No
Chemical Dependency	Yes	No	Kidney Problems	Yes	No	Ulcers-Stomach/Intestine	Yes	No
Chest Pain	Yes	No	Liver Disease/Hepatitis	Yes	No	Varicose Veins	Yes	No
Chronic Diarrhea	Yes	No	Nervous Problems	Yes	No	Venereal Disease	Yes	No
Circulatory Problems	Yes	No	Phlebitis	Yes	No	Weight Loss-unexplained	Yes	No

Surgeries (Circle): Heart Bypass Hysterectomy C-section Gallbladder Tonsils/Adenoids Appendix Foot/Ankle

Hospitalizations or other Surgeries: _____

Primary Physician: _____ Phone: _____ Date of Last Visit _____

Are you now, or have you been within the last two years, under any other doctor's care? Yes No

If yes, please explain the reason: _____

Are you pregnant? Yes No

MEDICATIONS

Include prescriptions, over-the-counter medications, vitamins and supplements:

Pharmacy Name/Phone#: _____

ALLERGIES

Adhesive/Tape	Local Anesthetics
Anticoagulant Therapy	Novocain
Aspirin	Penicillin
Codeine	Seafoods
Demerol	Sulfa
	Latex

Other _____

PODIATRIC HISTORY

What brings you to our office today?

Have you been treated for this problem before?

Yes No If yes, please list.

Physician: _____

Explain: _____

Do you have any personal or family history of **diabetes**? Yes No

Do you use alcohol? Yes No
How many drinks per week? _____

Do you use cigarettes/tobacco? Yes No
_____Packs/day for _____Years

Year Quit: _____

Who referred you to our office?

Is your condition directly related to employment or an auto accident?

Yes No

Is the condition related workman's compensation claim?

Yes No

Athletic activities in which you participate (please list and indicate frequency)

CONSENT FOR TREATMENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer treatment and/or perform any procedure(s) that are necessary in the diagnosis and/or treatment of my feet.

Patient's signature _____ Date _____

Physician Reviewed Information _____