

# Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

## Patient Information

Name \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_  
Last Name First Name Initial

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birth Date \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Patient employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_

Business Phone \_\_\_\_\_ Business Email \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Primary Insurance

Person Responsible for Account \_\_\_\_\_ Last Name First Name Initial

Relation to Patient \_\_\_\_\_ Birth Date \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Person Responsible employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_

Business Phone \_\_\_\_\_ Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

## Additional Insurance

Is patient covered by additional insurance?  Yes  No

Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birth Date \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_ Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

Please complete both sides.

# Patient Podiatric and Health Information

Family Physician \_\_\_\_\_

Last Visit \_\_\_\_\_

What is the nature of your foot problem? \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

Are you in good general health?  Y  N If no, explain \_\_\_\_\_

Are your feet tired at the end of the day?  Y  N Do you have lower back pain?  Y  N

Have you ever broken a bone in your foot or ankle?  Y  N Have you had previous foot/ankle surgery?  Y  N

Do you use tobacco products?  Y  N If yes, what amount daily? \_\_\_\_\_

## Medical History

Check (✓) if you have had any of the following:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cramps/Numbness in feet or legs | <input type="checkbox"/> Heart trouble       | <input type="checkbox"/> Liver trouble              |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Swelling of feet or ankles |
| <input type="checkbox"/> Bleeding disorder     | <input type="checkbox"/> Eye trouble                     | <input type="checkbox"/> Kidney trouble      | <input type="checkbox"/> Varicose veins             |

Are you allergic/sensitive to:

- |                                      |                                     |                                |
|--------------------------------------|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Anesthetics | <input type="checkbox"/> Materials  | <input type="checkbox"/> Tape  |
| <input type="checkbox"/> Drugs       | <input type="checkbox"/> Novocaine  | <input type="checkbox"/> Other |
| <input type="checkbox"/> Foods       | <input type="checkbox"/> Penicillin |                                |

List medications you are currently taking, if any:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Agreement To Pay: I understand that I am financially responsible for any charges deemed non-covered by my insurance company. I agree if my account is turned over for collections to pay all collection fees, attorney fees, and court costs. A fee of \$30.00 will be charged for any check returned for insufficient funds.**

## Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Payment is due in full at time of treatment unless prior arrangements have been approved.**