

J. W. Podiatry, P.C.

Podiatric Medicine
Foot Orthopedics and Surgery

PATIENT INFORMATION SUMMARY

Date: _____

Name: (first) _____ (last) _____ (middle initial) _____

Address: (street) _____ (city) _____ (state) _____ (zip) _____

Phone (home): (_____) _____ - _____ Phone (cell): (_____) _____ - _____

E-mail Address: _____

D.O.B: ____ / ____ / ____ Age: _____ Height: _____ Weight: _____ Sex: *M/F* Status: *S/M/D/W*

Shoe Size: _____ Employer: _____ Occupation: _____

Work Phone: (_____) _____ - _____ May we contact you at work? Yes / No

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Home Phone: _____ Cell: _____ Work Phone: _____ Ext: _____

PRIMARY CARE PHYSICIAN: _____

Address: (street) _____ (city) _____ (state) _____ (zip) _____

Phone: : (_____) _____ - _____ Fax: : (_____) _____ - _____

PHARMACY USED: _____ Phone: (_____) _____ - _____

Address: (street) _____ (city) _____ (state) _____ (zip) _____

INSURANCE INFORMATION

(*Please provide us with your insurance card and picture identification)

Medicare / Tufts / BCBS / HPHC / Other

Relationship to Subscriber: *Self/Dependent/Spouse*: (Name: _____ D.O.B: ____ / ____ / ____)

MEDICAL HISTORY *(may list on separate sheet)

Do YOU have a history of any of the following:

- | | | | | |
|------------------------------------|-----------------------------------|--------------------------------------------|----------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High BP | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Drug Use/Abuse |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Cancer: | <input type="checkbox"/> Alcohol Use |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Gout | <input type="checkbox"/> Smoking (Current/Former) |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ankle Sprains |

ALLERGIES:

Penicillin Local Anesthetic Aspirin Adhesive Tape Sulfur Other _____

Current MEDICATIONS: _____

Past SURGERIES: _____

REASON FOR TODAY'S VISIT: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE:

NAME _____ DATE _____

FAMILY HISTORY			
CAUSE OF DEATH			IS THERE A FAMILY (BLOOD RELATIVE) HISTORY OF: (PLEASE CHECK)
MOTHER	LIVING <input type="checkbox"/>	DECEASED <input type="checkbox"/>	<input type="checkbox"/> HEART DISEASE
FATHER	LIVING <input type="checkbox"/>	DECEASED <input type="checkbox"/>	<input type="checkbox"/> STROKE
BROTHER	LIVING <input type="checkbox"/>	DECEASED <input type="checkbox"/>	<input type="checkbox"/> ARTHRITIS
SISTER	LIVING <input type="checkbox"/>	DECEASED <input type="checkbox"/>	<input type="checkbox"/> BLEEDING DISORDER
			<input type="checkbox"/> HAMMERTOES
			<input type="checkbox"/> NEUROLOGICAL DISORDER
			<input type="checkbox"/> CIRCULATION PROBLEMS IN LEGS OR FEET
			<input type="checkbox"/> DIABETES WHO?

Review of Systems

Do you currently have problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in space provided

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Unexplained Weight Loss	Y	N
Other _____		

Eyes / Hearing

Poor Vision	Y	N
Blind	Y	N
Hard of Hearing	Y	N
Other _____		

Allergic / Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Other _____		

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/tingling	Y	N
Other _____		

Endocrine

Excessive Thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Excessive Urination	Y	N
Other _____		

Gastrointestinal

Abdominal Pain	Y	N
Nausea/vomiting	Y	N
Jaundice	Y	N
Indigestion/heartburn	Y	N
Constipation	Y	N
Diarrhea	Y	N
Other _____		

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
Phlebitis	Y	N
High Blood Pressure	Y	N
Claudication	Y	N
Ankle Swelling	Y	N
Other _____		

Dermatology

Skin Rash	Y	N
Moles	Y	N
Persistent Itch	Y	N
Other _____		

Musculoskeletal

Sciatica	Y	N
Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Other _____		

Respiratory

Wheezing	Y	N
Shortness of Breath	Y	N
Other _____		

Hematologic/Lymphatic

Swollen Glands	Y	N
Blood Clotting Problem	Y	N
HIV/Hepatitis A, B, C	Y	N
Other _____		

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Other _____		

Is there a possibility of you being pregnant (Woman)?	Y	N
Do you have a heart valve implant or pacemaker?	Y	N

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the J. W. Podiatry, P.C. *Notice of Privacy Practices* and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Patient initials: _____

AUTHORIZATION REGARDING PRIVACY POLICY

Due to the recent implementation of the Patient Privacy Act (HIPPA), it is necessary to obtain authorization for our office to leave messages at your home with family members and/or answering machines (voicemail) regarding the following; (1) confirm or change an appointment, (2) results of testing ordered by the physician, and/or (3) any pertinent information that may be relative to your care.

Patient initials: _____

PATIENT CONSENT TO TREATMENT

I hereby voluntarily consent to outpatient care by J. W. Podiatry encompassing routine care, diagnostic procedures, examination and medical treatment including, but not limited to minor surgical procedures, routine laboratory work, x-rays, ultrasound, laser and administration of medications and injections prescribed by J. W. Podiatry. I agree to ask questions to clarify treatment should I not understand the treatment plan.

Patient initials: _____

REFERRALS

For any insurance plan that requires (pre-)authorization from a primary care physician (e.g. HMO) it is your responsibility (as patient or guardian) to be sure that this office receives all necessary referrals or authorizations PRIOR to treatment. If the insurance carrier denies any charges due to lack of referral authorization, you (patient or guardian) are responsible for all charges incurred.

Patient initials: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have coverage with the insurance company(ies) disclosed and assign directly to J. W. Podiatry all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. **Please remember that you are responsible for all deductibles, co-insurances or other amounts not paid by your insurer.** We expect and appreciate payment for office visits at the time of service. **We will accept cash, check, Mastercard or Visa.** If any type of supplies are dispensed during the course of treatment (e.g. arch supports, accommodative pads, creams, shoes, etc.) payment is due at the time of service. We cannot bill you or the insurance company for these supplies.

J. W. Podiatry may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient initials: _____

This form has been explained to me (or I have read and understand the entire form) and I fully understand this Consent to Treatment and agree to its content.

This authorization is valid as of ____/____/____, the date I have signed below and will remain in effect as long as I am J. W. Podiatry's patient. I have read this complete page and agree to all of its contents.

Name of Individual/Legal Representative (PRINT)

Signature of Individual/Legal Representative

Supplemental information

My race is: American Indian or Alaskan Native _____ Asian _____ White _____ Black or African American _____ Native Hawaiian or Other Pacific Islander _____ Hispanic _____ Other _____

My ethnicity is: Hispanic or Latino _____ Not Hispanic or Latino _____

My Primary Language is: _____