

PODIATRIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____ First Name _____ Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____ Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named 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. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____
Name of

_____ for any services furnished to me by that provider.
Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative

Please print name of Beneficiary, Guardian or Personal Representative

Date _____ Relationship to Beneficiary

3 PHONE NUMBERS

Home Phone (____) _____

Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (____) _____

Work Phone (____) _____

4 PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

Is there any personal or family history of diabetes?
 Yes No

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____

Have you ever been to a Podiatrist before?
 Yes No

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

If yes, please list.

Name _____

Last visit _____

Please indicate which foot problems you now have or have had in the past.

- | | | |
|------------------------------------|------------------------------|-----------------------------|
| Ankle Pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Athlete's Foot | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bunions | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Corns and Calluses | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cramps or Numbness in Feet or Legs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Flat Feet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Foot or Leg Cramps | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heel Pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ingrown Toenails | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Plantar Warts | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Swelling in Ankles or Feet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tired Feet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

5

MEDICAL HISTORY

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

- | | | | | | |
|-----------------------------------|--|-----------------------|--|--------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Anesthetics | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Medicine or Drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Foot or Leg Cramps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves or Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling in Ankles, Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis or Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tired Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Varicose Veins | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chronic Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neuropathy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Phlebitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Ear Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Surgeries you have had _____

Hospitalization other than for the surgeries listed _____

Family physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? Yes No

If yes, please explain _____

6

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

Pharmacy Name(s) _____

Pharmacy Phone(s) (_____) _____

Do you take oral contraceptives? Yes No

7

ALLERGIES

- | | |
|--|--|
| <input type="checkbox"/> Adhesive/Tape | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Anticoagulant Therapy | <input type="checkbox"/> Novocaine |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Seafoods |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | |
| Other _____ | |

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Parkway Podiatry
248 Avenue P
Brooklyn, NY 11204

Date _____

Please print clearly

Name _____

Cell Phone _____

Email _____

Height _____

Weight _____

Shoe Size _____

Occupation _____

Smoke ___ppd x ___years

Drinking ___social___moderate___heavy

Activities: Sports _____

Exercise ___ times per week for ___ minutes per session

Family History (*circle all applicable*)

Heart Disease | Diabetes | Stroke | Arthritis | Kidney Disease | Cancer
G F M S B | G F M S B | G F M S B | G F M S B | G F M S B | G F M S B
G= grandparent F=father M= mother S= sister B= brother

Describe the problem that brings you here:

How long have you had this problem?:

What makes it better? What makes it worse?:

What have you done to make it better?:

If any, rate the pain on a scale of 1 through 10 ("*1*" is no pain and "*10*" is unbearable)

1 2 3 4 5 6 7 8 9 10 (*circle one*)

Signature