Podiatric Registration and History- Austin Podiatry P.A.

Patient Information

Date____

Patient's Name______________________________

Birthday _______________Age ________________

Sex ___M ___F

Weight______________ Height ________________

Address_____________________________________
_____________________Apt #_________________

City___________ State __________ Zip___________

Single___Married___Widowed___Separated___Divorced___

Patient SSN__________________________________

Occupation__________________________________

Employer____________________________________

Employer Address ___________________________

Employer Phone _____________________________

Family Physician_____________________________

Spouse's Name ______________________________

Whom may we thank for referring you?

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Contact Information

Home_______________ Cell ___________________

E-mail_____________________________________

Emergency Contact Name ____________________

Relationship_________ Phone _________________

Insurance

Who is responsible for this account ____________________
Relationship to patient ________________________________
Insurance Co.____
Group #____
Is patient covered by additional insurance? Yes____No____
Subscriber Name _______________________________________
Birthday __________________ SSN____________________
Relationship to patient ________________________________
Insurance Co____
Group # ____

Assignment and Release

I, the undersigned certified that I (or my dependent) have insurance coverage with ________________ 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 hereby authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of this signature on all insurance submissions.

X ____

Responsible Party Signature

Relationship ______________ Date ___________________

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. __________ for any services furnished me by that physician. 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 relate services. I understand my signature requests that payment be made and authorizes release of medical 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 ass the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

X ____

Beneficiary Signature

Podiatric History

What brings you to our office today?
____

Have you seen a podiatrist before? Yes___ No____

Name________________ Last Visit ______________

Please circle any current or past foot problems

Ankle pain	Athlete's foot
Bunions	Corns and callouses
Heel pain	Ingrown toenails
Wart	Tired feet/flatfoot

Cramp or numbness in feet or legs
Swelling of the ankles or feet

Medical History

Circle any problems that you have or have had.

AIDS/HIV
Allergies to anesthetics
Allergies to medicine or drugs
Anemia
Angina
Anxiety issue
Arthritis
Artificial heart valves or joints
Asthma
Back problems
Bleeding disorders
Cancer
Chemical dependency
Chest pain
Chronic diarrhea

Circulatory problem
Diabetes (A1C __________)
Ear problems
Epilepsy
Eye problems
Fainting
Fevers, chills, nausea or vomiting
Gout
Headaches
Heart disease
Hemophilia
Hepatitis or jaundice
High/low blood pressure
Kidney problems
Pain Problem

Phlebitis
Psychiatric care
Radiation treatment
Rash
Respiratory disease
Rheumatic fever
Shortness of breath
Sinus problems
Special diet
Stroke
Swollen neck glands
Tuberculosis
Ulcers
Varicose veins
Venereal disease
Unexplained weight loss

List all medical conditions that are not circled above.

Past surgeries____

Past hospitalization____

Are you now, or have been under any other doctor's care for any reason over the past 2 years? Yes ______ No______
If yes, please explain ____

List any illnesses that runs in the family ____

Medications

Please list any prescription or over-the-counter medications and vitamins

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Pharmacy name___________________ Pharmacy Phone # _____________
Pharmacy Address ____
Do you take oral contraceptives? Yes ____ No ____

Allergies

(Please circle any allergies you have)

Local anesthetics
Penicillin
Sulfa drugs
Adhesive/Tape
Iodine
Other____________________________

Social History

Your occupation ___________________ How often do you exercise per week (Hours)________________________

Cigarette/tobacco use? Yes ___ No____ If yes, for how many years ______ How many packs per day _____

Alcohol consumption? Yes ____ No ____ If yes, how much per week _______

Consent

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 and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature ____ Date ________________________