1 PATIENT IDENTIFICATION AND DEMOGRAPHICS

First name:	MI:	Last name:	Gender: M or F
Address:	City:	State:	ZIP:
Home phone:	Cell phone:	Work phone:	
Date of birth:	Pt SSN:	Email:	How do you prefer to be contacted? (*circle*) Home Cell Work Email
In case of emergency, please contact:		Phone:	
Preferred pharmacy:		Phone:	

2 COMPREHENSIVE PATIENT MEDICAL HISTORY

Have you had/been treated for?

☐ Warts	☐ Ingrown nails	☐ Corns/Calluses
☐ Fungal nails	☐ Foot numbness	☐ Leg or foot ulcers
☐ Neuroma	☐ Ankle sprain	☐ Broken bones in feet/ankles
☐ Bunions	☐ Flat feet	☐ Hammer/Mallet toes
☐ Arch pain	☐ High arch feet	☐ Cramps in legs/feet
☐ Knee pain	☐ Heel pain	☐ Lower back pain
☐ In-toeing	☐ Corns/Calluses	☐ Gait (walking) problems
☐ Rash	☐ Toe walking	☐ Childhood foot problems
☐ Athlete's foot	☐ ***None of these***	

List relationship to you of family members who have had:

Diabetes_____ Foot problems_____

Arthritis_____ Heart attack_____

Stroke_____ High blood pressure_____

Cancer_____ Birth defects_____

# of child births	☐ Yes	☐ No
Are you currently pregnant?	☐ Yes	☐ No
Are you slow to heal after cuts?	☐ Yes	☐ No
Abnormal bruising/ bleeding/scarring	☐ Yes	☐ No

Did you previously or do you now wear?

☐ Shoe inserts Still using? **Y N** Do/did they help? **Y N**

☐ Orthotics Still using? **Y N** Do/did they help? **Y N**

The orthotics were obtainted from: ☐ Another Podiatrist

☐ Orthopedist ☐Physical Therapist ☐hiropractor ☐ther

Are your first steps out of bed painful? **Y N** Subsides? **Y N**

Do you get leg cramps during the day? **Y N** At night? **Y N**

What % of the day do you spend walking? 20% 40% 60% 80% 100%

Occupation or activities you participate in: _____

Do you smoke now? **Y N** Packs/day___ Years____

Have you ever smoked? **Y N** Packs/day___ Years____

If you quit, when?_____

Alcoholic beverages? (*circle one*)

None Rarely Moderately Daily Quit

Recreational drugs? (*circle one*)

None Rarely Moderately Daily Quit

Current medications: _____

Does the foot pain limit your desired activities?	☐ Yes	☐ No
Do you have any difficulty walking?	☐ Yes	☐ No
Any pain in calves or buttocks when walking?	☐ Yes	☐ No
Is the pain relieved by stopping or standing still?	☐ Yes	☐ No

Do you have or have you ever been treated for:

☐ Stroke	☐ High blood pressure	☐ Heart attack
☐ Phlebitis	☐ Heart condition	☐ Vascular disease
☐ Diabetes	☐ Headaches	☐ Poor circulation
☐ Hepatitis	☐ Anemia	☐ Liver disease
☐ Gout	☐ Keloid/thick scar	☐ Arthritis
☐ Sciatica	☐ Osteoporosis	☐ Rheumatic fever
☐ Alzheimer's	☐ Lyme disease	☐ Nerve disorder
☐ Epilepsy	☐ Hearing/ear disorder	☐ Kidney disease
☐ Glaucoma	☐ Psychiatric disorder	☐ Lung disease
☐ Asthma	☐ Thyroid problem	☐ Stomach ulcer
☐ Cancer	☐ Tuberculosis	☐ ***NONE of these***
☐ Other:		

Drug allergies: If yes, what happens?

☐ No know drug allergies

☐ Penicillin _____

☐ Other antibiotics _____

☐ Morphine _____

☐ Codeine _____

☐ Demerol _____

☐ Novocaine _____

☐ Aspirin _____

☐ Tylenol _____

☐ Advil, Aleve, Motrin _____

☐ Sulfa drugs _____

☐ Adhesive tape _____

☐ Iodine or seafood _____

☐ Others:

Do you have vascular grafts? (*If yes, explain below*) ☐Yes ☐No

Do you have joint implants? (*If yes, explain below*) ☐Yes ☐No

Do you have replacement heart valves?
(*If yes, explain below*) ☐Yes ☐No

Are you now under active chemotherapy?
(*If yes, explain below*) ☐ Yes ☐ No

Have you had any other serious illness? (*If yes, explain below*) ☐ Yes ☐ No

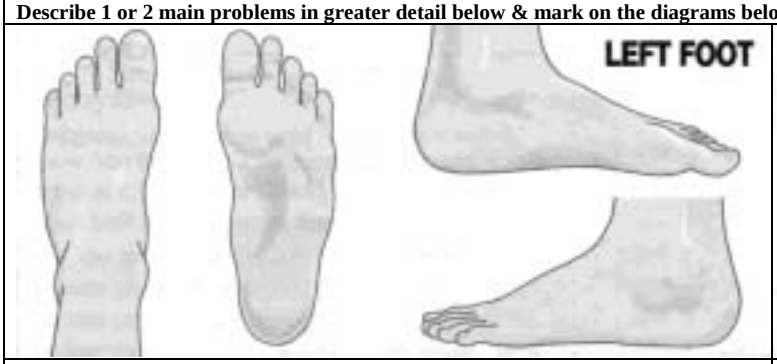
Have you had any surgery? (*If yes, explain below*) ☐ Yes ☐ No

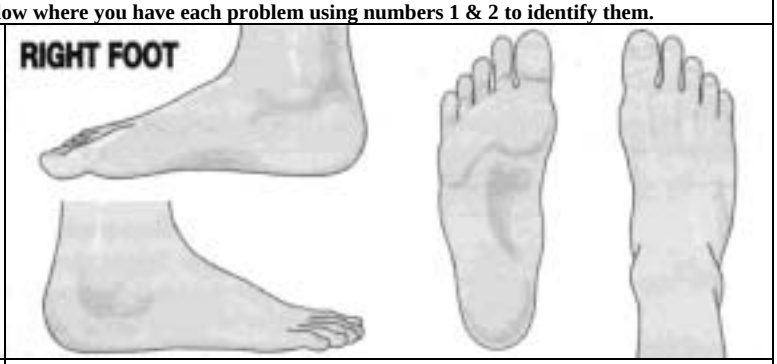
Have you been hospitalized or been under medical care over 24 hours? ☐ Yes ☐ No

3 Patient's Current Chief Complaints

Patient CC# (s)

Describe 1 or 2 main problems in greater detail below & mark on the diagrams below where you have each problem using numbers 1 & 2 to identify them.





❶ Please mark the location of your first problem or pain on the diagrams above with a number 1. Describe your problem below and its cause if you know. **Please describe associated pain to the right ➔**

My first problem is … ☐ **On Left foot** ☐ **On Right foot** ☐ **On Both feet**

It cause me difficulty: ☐ **walking,** ☐ **wearing shoes, and/or it …**

_____

_____

_____

_____

_____

_____

_____ **Is problem work related?** ☐**Y** ☐**N**

Date of injury: / / **Date of report to employer:** / /

Pain: Please indicate the severity of your pain or discomfort:

☐**None…** ☐**Mild…** ☐**Moderate…** ☐**Strong…** ☐**Severe**

My Pain/Discomfort is:

☐**Shooting Pain**
☐**Throbbing Pain**
☐**Sharp Pain**
☐**Burning Pain**
☐**Itching Pain**
☐**Aching Pain**
☐**Tenderness**
☐**Dull Pain**
☐**Tingling**
☐**Numbness**

How long ago did the problem (pain) start?:

_____ O days, O weeks, O months, O years ago

The pain from my problem occurs:

☐ while walking and/or ☐ while not walking

☐ and/or: _____

_____

Previous medical treatment(s) or home remedies:

_____

_____

_____

_____

❷ Please mark the location of your second problem or pain on the diagrams above with a number 2. Describe your problem below and its cause if you know. **Please describe associated pain to the right ➔**

My second problem is … ☐ **On Left foot** ☐ **On Right foot** ☐ **On Both feet**

It cause me difficulty: ☐ **walking,** ☐ **wearing shoes, and/or it …**

_____

_____

_____

_____

_____

_____

_____ **Is problem work related?** ☐**Y** ☐**N**

Date of injury: / / **Date of report to employer:** / /

Pain: Please indicate the severity of your pain or discomfort:

☐**None…** ☐**Mild…** ☐**Moderate…** ☐**Strong…** ☐**Severe**

My Pain/Discomfort is:

☐**Shooting Pain**
☐**Throbbing Pain**
☐**Sharp Pain**
☐**Burning Pain**
☐**Itching Pain**
☐**Aching Pain**
☐**Tenderness**
☐**Dull Pain**
☐**Tingling**
☐**Numbness**

How long ago did the problem (pain) start?:

_____ O days, O weeks, O months, O years ago

The pain from my problem occurs:

☐ while walking and/or ☐ while not walking

☐ and/or: _____

_____

Previous medical treatment(s) or home remedies:

_____

_____

_____

_____

4 Patient's Doctors – Please Tell Us Whom To Thank And With Whom to Coordinate Your Care

My:	Physician's Name:	Phone Number	City	Date Last Seen	Referred me:	I was sent or came in especially for:
Family/ Primary	_____	_____	_____	___/___/___	☐**Y** ☐**N**	**2nd Opinion / Surgcl Eval / Consult**
Specialist	_____	_____	_____	___/___/___	☐**Y** ☐**N**	**2nd Opinion / Surgcl Eval / Consult**
Other Podiatrist	_____	_____	_____	___/___/___	☐**Y** ☐**N**	**2nd Opinion / Surgcl Eval / Consult**

5 For Doctor's Use – Observations & Comments

☐ Patient was O assisted in completion of this record by or was O unable to complete without the help of _____

☐ Additional information obtained from O Family/Care givers and/or O Physician(s)_____

☐ Lab Reports and/or ☐ Previous Medical Records were reviewed. ☐ X-rays brought by patient from _____ were reviewed.

Elaborations: _____

_____

_____

_____

_____

I have reviewed the information provided above_____. ☐ My annotations to patient's entries are marked in: _____

Doctor's Signature **X** _____Date____/____/_____ **(INK COLOR)** ☐ See Additional Documentation

☐ **Only Changes To The Previous History Information Are Noted**

Financial Policy for Memorial Podiatry Group

We are dedicated to providing great care to our patient's and assisting you in any way to achieve reimbursement for our services from your insurance company. We will send in the claims to the insurance company on your behalf. If there are services which are excluded from coverage by your specific policy we are often not aware of this and so it is the patient's responsibility to know what their policy covers. (Exception: We check benefits prior to surgery in the hospital/surgery center to verify benefits).

Some services that we provide may not be covered, or have limits on coverage: 1) Debridement of toenails and trimming of calluses, 2) Durable medical equipment items such as braces, post-op shoes/cam walkers.

Medications, topical solutions and items we have available for purchase are non-covered items by all insurance plans and will not be billed to your insurance company for reimbursement. These items are to be paid for at the time of service.

Change of Coverage: Please let us know if you change your insurance and provide the office with the new card. Insurance companies allow only a small period of time to file claims. If we submit to the wrong company your claim may be denied by the correct company and the balance due becomes the responsibility of the patient. The only way we know if you have different insurance is if you tell us.
Please provide us with your updated card to photocopy as soon as you receive one.

Copayments: Copayments are required when services are rendered per your contract with the insurance company. We accept VISA, MasterCard, American Express and Discover. You may also pay with cash or a check. We prefer to get to know you before paying with a check. New patients should use credit or cash for their copayments, please.

By my signature, I agree that I have read the above financial policy and agree to its terms. I further acknowledge that non-covered items/services are my financial responsibility.

Patient Signature/ Legal Guardian _____
Patient Name/Legal Guardian _____ Date_____

Privacy Notice Summary:

Uses of Health Information: We will use your health information to treat and assist other healthcare providers in treating you, to bill insurance claims for payment and for licensing, credentialing and training of students who are covered under our HIPPA policy in this office.
Your Authorization: We will obtain your authorization before releasing your private information to anyone other than those listed in the paragraph above.
Uses not requiring your Authorization: We may disclose your information in some circumstances such as: Family members involved in your care, limited research purposes, public health and safety purposes, Government audits and investigations, FDA reports, law enforcement authorities to protect the public, and when required by court orders.
Patient Rights: You have a right to access/copy health information, discuss your information confidentially with us, and restrict how the health information is used. If you would like a detailed Privacy Notice, please ask at our front desk.

I acknowledge that I was provided with a summary of the privacy notices and have read and understood them. I can receive a complete copy of the entire Privacy Summary at my request from this office.
Patient Signature/ Legal Guardian _____
Patient Name/Legal Guardian _____ Date_____