Patient Information Sheet

Patient (First) (Last) (Mid. Intl) .(Gender) M ☐ F ☐

Social Security# Date of Birth / / .Email .

Address Line 1 .

Address Line 2 .

City . State . Zip Code .

Phone: Home (___)____-_____ Work (___)____-_____ Cell – (___)____-)_____

Family Physician . Phone (____)____-_____

Date Last Seen by Family Physician .

Primary Insurance Company .

Insurance ID# .Co-pay $.

Subscriber Name .Relationship to Patient .

Subscriber Birth Date: ___/___/_____.

Second Insurance Company .

Insurance ID# .

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____, and assign directly to Petoskey Family Foot Care, 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 of benefits. I authorize the use of this signature on all insurance submissions.

RESPONSIBLE PARTY SIGNATURE _____.

Relationship _____ .Date___/___/_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to me on my behalf to Petoskey Family Foot Care, release to the Health Care Financing Administration and its agents any information needed to determine these benefits. I understand that my signature requests that payment be made and authorize release of medical information necessary to pat the claim. If “other health insurance” is indicated on 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 claims, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services.

BENEFICIARY SIGNATURE .Date___/___/_____

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Allergies: (Circle ones that apply)

NONE Adhesive/Tape Anticoagulant Therapy Aspirin Demerol Codeine Iodine Local Anesthetics Latex Novocaine Penicillin Sulfa Seafood Other _____.

Medications .

Include prescriptions, over-the-counter medications and vitamins_____.

_____.

. _____.

_____.

Circle past and present health issues .

Constitutional

Good general health
Celiac
Kidney disease
Weight gain
Weight loss
Dizziness

Cardiovascular

Anemia
Angina
Ankle swelling
Artificial heart valves
Calf cramping
Cardiac stents
Cardiovascular problems
Change in color of extremity
Chest pain
Circulatory problems
Claudication
Cold feet
Fainting
Foot or Leg cramps
Heart disease
High blood pressure
High cholesterol
Pacemaker
PAD noted by MD
Raynaud's
Smoker
Varicosities

Musculoskeletal

Arthritis
Artificial Joints
Back problems/ pain
Gout
Heel pain
Hip replacement
History of falls
Knee replacement
Lupus
Lyme disease
Morning stiffness
Osteoporosis
Weakness

Integument (skin and nails)

Athlete's foot
Blisters
Callous
Dry scaly skin
Eczema
Ingrown nails
Itchy skin
Lower leg ulcers
Non-healing wound
Psoriasis
Rash
Warts

Neurologic

Burning sensation
Diabetic neuropathy
Headaches
Hypersensitivity
Numbness
Restless leg syndrome

Circle past and present health issues - continued

Endocrine

Diabetes / Is there a family history?
Thyroid disease

Other

Cancer
Eye problems

Lymphatic/Hematology

Anemia
Ankle edema
Blood thinner
Bleeding disorder
Bruise easily
Hemophilia
History of Phlebitis

Respiratory

Asthma
COPD

Surgical History

Surgeries you have had in the past

_____.

_____.

Smoking / Tobacco Use; No____Yes_____How many years?_____

Height___'_____" Weight_____ Blood Pressure____/_____ Shoe size_____

What is the chief complaint for which you came to be treated?_____.

_____.

Have you ever been to a podiatrist before?_____

If yes, please list doctor's name_____

Date of last visit____/____/_____

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 Signature _____. Date ____/____/_____