



PLEASE READ AND COMPLETE ALL PORTIONS

CONFIDENTIAL PATIENT INFORMATION

NAME _____ BIRTHDATE _____ AGE _____

SOCIAL SECURITY # _____ SEX MALE _____ FEMALE _____

MARITAL STATUS MARRIED _____ SINGLE _____ WIDOW _____ DIVORCE _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

OCCUPATION _____ EMPLOYER _____

NAME OF SPOUSE OR PARENT _____

SPOUSE OCCUPATION _____ EMPLOYER _____

SPOUSE WORK PHONE _____ CELL PHONE _____

IN CASE OF EMERGENCY, CONTACT _____

RELATIONSHIP _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

NAME _____ ADDRESS _____

FAMILY DOCTOR _____ PHONE _____

HAVE YOU EVER BEEN TREATED BY A PODIATRIST BEFORE? YES _____ NO _____

PODIATRIST _____ PHONE _____

LAST VISIT DATE & REASON _____

MY FOOT PROBLEM IS _____

DO YOU USE TOBACCO? YES _____ NO _____ PACKS PER DAY _____ YEARS _____

DO YOU USE ALCOHOL? YES _____ NO _____ AMOUNT _____

LIST ANY STREET DRUGS OR SUBSTANCES YOU HAVE USED? _____ NONE _____

DO YOU HAVE ANY PROBLEMS WITH ANESTHESIA? YES _____ NO _____ EXPLAIN _____

FEMALES, COULD YOU BE PREGNANT? YES _____ NO _____ DATE OF LAST PERIOD _____

DO YOU HAVE ANY CULTURAL OR RELIGIOUS PRACTICES THAT WILL IMPACT YOUR HEALTH CARE?

YES _____ NO _____ IF YES, EXPLAIN _____

PHARMACY _____ PHARMACY PHONE _____ STREET INTERSECTION _____



CONFIDENTIAL PATIENT INFORMATION

NAME _____ BIRTHDATE _____

PLEASE CHECK ANY PROBLEMS YOU HAVE NOW OR EVER HAD IN THE PAST:

- | | | |
|---|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Mental Health Problems |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Nerve Injury |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Asthma | <input type="checkbox"/> Herniated Disc |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Back Injury |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Neck Injury |
| <input type="checkbox"/> Diabetes Type 1 ____ Type 2 ____ | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Last A1C: _____ Date: _____ | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Steroid Use | <input type="checkbox"/> Frequent Heartburn | <input type="checkbox"/> Prosthetics |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Motion Sickness |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Eye Problems |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke | <input type="checkbox"/> GI / Colon Problems |
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Fainting or Blackouts | |

Height: _____

Weight: _____

Shoe Size: _____

LIST ANY MEDICAL PROBLEMS NOT LISTED ABOVE:

LIST ALL PREVIOUS SURGERIES:

CURRENT MEDICATIONS (include non-prescriptions medicine, vitamins and herbal supplements)

Name	Dose	Schedule	Last Taken
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			
6. _____			
7. _____			

DO YOU HAVE ANY ALLERGIES to medications, foods, environmental substances, tape, latex, dye, etc.? YES NO

LIST: _____



NAME _____ BIRTHDATE _____

INSURANCE INFORMATION (Please allow receptionist to photocopy your insurance ID cards)

If someone other than patient is the insured part, please include date of birth for claims

PRIMARY INSURANCE

PLAN NAME _____ *INSURED NAME _____

INSURED'S SOCIAL SECURITY _____ INSURED'S DATE OF BIRTH _____

*POLICY / ID # _____ *GROUP ID # _____ EFF. DATE _____

CLAIMS ADDRESS _____ CITY _____ ST _____ ZIP _____

CLAIMS PHONE # _____

SECONDARY INSURANCE

PLAN NAME _____ *INSURED NAME _____

INSURED'S SOCIAL SECURITY _____ INSURED'S DATE OF BIRTH _____

*POLICY / ID # _____ *GROUP ID # _____ EFF. DATE _____

CLAIMS ADDRESS _____ CITY _____ ST _____ ZIP _____

CLAIMS PHONE # _____

GUARANTOR INFORMATION (List person or insured name responsible for bill – use full legal name – no nicknames) RELATIONSHIP

OF GUARANTOR TO PATIENT SELF SPOUSE PARENT OTHER LAST NAME _____

FIRST NAME _____ SOCIAL SECURITY _____ HOME ADDRESS _____

_____ ZIP CODE _____ * EMPLOYER

NAME _____ PHONE _____

FINANCIAL RESPONSIBILITY AGREEMENT

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the physician or the physicians' staff to know if my insurance will pay for any medical service I receive.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limit, or any other type of benefit limitation for the medical services I receive.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out-of-pocket expense to me. I understand this and agree to be financially responsible for all charges.

I understand and agree it is my responsibility to know if my PCP (Primary Care Physician) choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

SIGNATURE _____ DATE _____

(PLEASE SIGN HERE – PATIENT OR RESPONSIBLE PARTY)

RESPONSIBLE PARTY NAME _____



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Additional Patient History Information:

For all patients: (Circle One)

Have you received a flu vaccination for the **CURRENT** season? YES NO

If NO, what was the reason? Patient Allergy Patient Declined Vaccine Unavailable

Have you received the COVID-19 Vaccination? YES NO

If so, which brand? Moderna Pfizer Johnson & Johnson's Janssen

Date(s) of shots: Dose 1: _____ **If applicable,** Dose 2: _____

For patients 65 years of age and older: (Circle One)

Do you have a Living Will or someone to make decisions on your behalf? YES NO

Have you had a Pneumonia Vaccination? YES NO