J. W. Podiatry, P.C.

Podiatric Medicine
Foot Orthopedics and Surgery

PATIENT INFORMATION SUMMARY

Date: ________________

Name: (first) ______________________________ (last) ______________________________ (middle initial) ________

Address: (street) ____________________________________ (city) __________________ (state) ______ (zip) __________

Phone (home): (_______) _______ - _________________ Phone (cell): (_______)_______ - _________________

E-mail Address: ____

D.O.B: _____ /_____/_____ Age: ________ Height: _________ Weight: __________ Sex: ***M/F*** Status: ***S/M/D/W***

Shoe Size: _____________ Employer: _____________________________________ Occupation: __________________

Work Phone: (_______) _______ - _________________ May we contact you at work? Yes / No

IN CASE OF EMERGENCY, CONTACT:

Name: ____ Relationship: ______________________________

Home Phone:_____________________ Cell:____________________ Work Phone:_____________________ Ext: ________

PRIMARY CARE PHYSICIAN: ____

Address: (street) ____________________________________(city) __________________ (state) ______ (zip) __________

Phone: : (_______) _______ - _________________ Fax: : (_______) _______ - _________________

PHARMACY USED: ____ Phone: (_______) _______ - ____________

Address: (street) ____________________________________ (city) __________________ (state)______ (zip) __________

INSURANCE INFORMATION

(*Please provide us with your insurance card and picture identification)

Medicare / Tufts / BCBS / HPHC / Other

Relationship to Subscriber: *Self/Dependent/Spouse: (Name:* ________________________________ *D.O.B: ___/ ___ /_____)*

MEDICAL HISTORY *(may list on separate sheet)

Do YOU have a history of any of the following:

☐ Diabetes ☐ High BP ☐ Heart Disease ☐ Liver Disease ☐ Drug Use/Abuse
☐ Arthritis ☐ Anemia ☐ Bleeding Disorder ☐ Cancer: ☐ Alcohol Use
☐ Hepatitis ☐ Asthma ☐ Rheumatic Fever ☐ Gout ☐ Smoking (Current/Former)
☐ HIV/AIDS ☐ Epilepsy ☐ Artificial Joint ☐ Tuberculosis ☐ Ankle Sprains

ALLERGIES:

☐ Penicillin ☐ Local Anesthetic ☐ Aspirin ☐ Adhesive Tape ☐ Sulfur ☐ Other ______________________________

Current MEDICATIONS: ____

____

____

____

Past SURGERIES: ____

____

REASON FOR TODAY'S VISIT: ____

____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE:

____

NAME ____________________ DATE ____________

FAMILY HISTORY

			CAUSE OF DEATH
MOTHER	LIVING ☐	DECEASED ☐	________
FATHER	LIVING ☐	DECEASED ☐	________
BROTHER	LIVING ☐	DECEASED ☐	________
SISTER	LIVING ☐	DECEASED ☐	________

IS THERE A FAMILY (BLOOD RELATIVE) HISTORY OF: (PLEASE CHECK)

☐ HEART DISEASE	☐ STROKE
☐ ARTHRITIS	☐ BUNIONS
☐ BLEEDING DISORDER	☐ HAMMERTOES
☐ NEUROLOGICAL DISORDER	☐ CIRCULATION PROBLEMS IN LEGS OR FEET

☐ DIABETES WHO?

Review of Systems

Do you currently have problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in space provided

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Unexplained Weight Loss	Y	N
Other ________		

Eyes / Hearing

Poor Vision	Y	N
Blind	Y	N
Hard of Hearing	Y	N
Other ________		

Allergic / Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Other ________		

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/tingling	Y	N
Other ________		

Endocrine

Excessive Thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Excessive Urination	Y	N
Other ________		

Gastrointestinal

Abdominal Pain	Y	N
Nausea/vomiting	Y	N
Jaundice	Y	N
Indigestion/heartburn	Y	N
Constipation	Y	N
Diarrhea	Y	N
Other ________		

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
Phlebitis	Y	N
High Blood Pressure	Y	N
Claudication	Y	N
Ankle Swelling	Y	N
Other ________		

Dermatology

Skin Rash	Y	N
Moles	Y	N
Persistent Itch	Y	N
Other ________		

Musculoskeletal

Sciatica	Y	N
Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Other ________		

Respiratory

Wheezing	Y	N
Shortness of Breath	Y	N
Other ________		

Hematologic/Lymphatic

Swollen Glands	Y	N
Blood Clotting Problem	Y	N
HIV/Hepatitis A, B, C	Y	N
Other ________		

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Other ________		

Is there a possibility of you being pregnant (Woman)? Y N

Do you have a heart valve implant or pacemaker? Y N

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge that I was provided a copy of the J. W. Podiatry, P.C. *Notice of Privacy Practices* and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Patient initials: ______

AUTHORIZATION REGARDING PRIVACY POLICY
Due to the recent implementation of the Patient Privacy Act (HIPPA), it is necessary to obtain authorization for our office to leave messages at your home with family members and/or answering machines (voicemail) regarding the following; (1) confirm or change an appointment, (2) results of testing ordered by the physician, and/or (3) any pertinent information that may be relative to your care.

Patient initials: ______

PATIENT CONSENT TO TREATMENT
I hereby voluntarily consent to outpatient care by J. W. Podiatry encompassing routine care, diagnostic procedures, examination and medical treatment including, but not limited to minor surgical procedures, routine laboratory work, x-rays, ultrasound, laser and administration of medications and injections prescribed by J. W. Podiatry. I agree to ask questions to clarify treatment should I not understand the treatment plan.

Patient initials: ______

REFERRALS
For any insurance plan that requires (pre-)authorization from a primary care physician (e.g. HMO) it is your responsibility (as patient or guardian) to be sure that this office receives all necessary referrals or authorizations PRIOR to treatment. If the insurance carrier denies any charges due to lack of referral authorization, you (patient or guardian) are responsible for all charges incurred.

Patient initials: ______

INSURANCE ASSIGNMENT AND RELEASE
I certify that I have coverage with the insurance company(ies) disclosed and assign directly to J. W. Podiatry all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. ***Please remember that you are responsible for all deductibles, co-insurances or other amounts not paid by your insurer.*** We expect and appreciate payment for office visits at the time of service. ***We will accept cash, check, Mastercard or Visa***. If any type of supplies are dispensed during the course of treatment (e.g. arch supports, accommodative pads, creams, shoes, etc.) payment is due at the time of service. We cannot bill you or the insurance company for these supplies.

J. W. Podiatry may use my health care information and may disclose such information to the disclosed 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.

Patient initials: ______

This form has been explained to me (or I have read and understand the entire form) and I fully understand this Consent to Treatment and agree to its content.

This authorization is valid as of _____/ _____/ _____, the date I have signed below and will remain in effect as long as I am J. W. Podiatry's patient. I have read this complete page and agree to all of its contents.

___________________________________	___________________________________
Name of Individual/Legal Representative (PRINT)	***Signature of Individual/Legal Representative***

Supplemental information

My race is: American Indian or Alaskan Native ______ Asian______ White______ Black or African American _____ Native Hawaiian or Other Pacific Islander______ Hispanic ______ Other ______

My ethnicity is: Hispanic or Latino ______ Not Hispanic or Latino ______

My Primary Language is:____