WELCOME TO OUR OFFICE
(**PLEASE PRINT** and **FILL OUT COMPLETELY)**

**Date**_____

**Name**_____**Spouse's Name**_____

**Address**_____**City**_____**Zip**_____

**Phone #: Home**_____**Cell**_____**Business**_____

**E-Mail Address**_____ **SSN** (optional)_____

**Age**_____**Date of Birth**_____**Gender**_____ **Marital Status: S M W D**

**Full Time Student:** _____ Yes _____ No **Parent or Guardian's name**_____

**Party responsible for payment of account:** _____

**Address**_____

**Phone**_____

**In case of Emergency, please first call:**_____
**Phone Number**

_____
**PATIENT (OR PARENT'S) OCCUPATION** **EMPLOYER** **Phone Number**

_____
**SPOUSE'S EMPLOYER** **Phone Number**

**Whom may we thank for referring you to our office?**_____

**Primary Physician's Name and Address**_____
**Approx. Date of Last Visit**

**Former Podiatrist**_____
**Approx. Date of Last Visit**

Briefly Describe Your **PRESENT FOOT/ANKLE PROBLEM:**_____

_____

**Pain Level:** **0** (no pain) **1 2 3 4 5 6 7 8 9 10** (most severe pain of your life)

**INSURANCE INFORMATION:**

Do you have **MEDICARE?** **____Yes ____No Medicare Number:**_____
Do you have **MEDICAID?** **____Yes ____No**

**Insurance Coverage (primary):**_____

**(secondary):**_____

Please provide photo identification (such as a State ID) to the receptionist. This is for your protection and to abate fraud.
I authorize the release of information to all of my insurance companies.
I authorize **PODIATRY CENTER, INC.** to act as my agent in helping me obtain payment from my insurance companies.
I authorize payment direct to **PODIATRY CENTER, INC.** (Dr. Springer).
I understand that I am responsible for my entire bill in the event my insurance does not pay.

**SIGNATURE:**_____**DATE:**_____

# PATIENT MEDICAL HISTORY

**Patient's Name:**_____**Date:**_____

**Height:**_____ **Weight:**_____ **Shoe Size:** _____

**___ I am NOT allergic to and have not had any adverse reaction to any substance to my knowledge**
**___ I AM allergic to or have had an adverse reaction to** (please check those items that apply):
___Novocain ___Local anesthesia ___General anesthesia ___Penicillin___Sulfa ___Ibuprofen
___Naproxen ___Aspirin ___Vicodin ___Demoral ___Codeine ___Percocet ___Iodine
___Shell Fish ___Eggs ___Adhesive/Tape ___Other: _____ _____
Reaction?_____ _____ _____

**Do you have or have you ever been treated for:**
___Diabetes (how long?):_____Last A1c?____ ___Cancer (type?):_____ ___Kidney Disease
___Stroke ___Asthma ___Anemia ___Phlebitis ___Bleeding Tendencies
___Lung Disease ___Gout ___Vascular disease ___Stomach Ulcers ___Sciatica
___Osteoarthritis ___Rheumatoid Arthritis ___Lupus ___Poor Circulation ___Alzheimer's/Dementia
___Liver Disease ___Thyroid Disease ___Glaucoma ___Heart Condition ___High Blood Pressure
___Joint Implants ___ICD/Pacemaker ___AIDS ___HIV positive ___Hepatitis A
___Hepatitis B ___Hepatitis C ___**OTHER**:_____ _____
___None of these _____ _____

**Past Surgeries** (with approx. dates):_____
Please include all surgeries.
_____

**CURRENT MEDICATIONS and dosage:**_____ _____ _____
Please include prescription and over-the-counter medications.
Please provide a list if you need additional room.

**List the relationship to you of <u>FAMILY MEMBERS</u> who have had:**
Diabetes_____ Arthritis_____
Heart Disease_____ Cancer_____(type?):_____

**Are you currently pregnant?** **___Yes ___No**
**Are you slow to heal after cuts?** **___Yes ___No**
**Do you have any abnormal bruising, bleeding, or scarring?** **___Yes ___No**
**Do you smoke?**(please provide packs per day & years smoked) **___Yes ___No** _____
**Packs Per Day Years Smoked Quit Date**
**Do you use any type of tobacco? Type?** **___Yes ___No** _____
**Type of tobacco**
**Do you drink alcohol?** **___Yes ___No**
**Drinks per day?** _____
**Do you use any illicit or recreational drugs? Type?** **___Yes ___No** _____
**Type of illicit/recreational drug**

**Do you have** (check all that apply):
___joint aches or pains ___hip pain ___low back pain ___knee pain ___ankle pain ___foot pain
___joint swelling ___limited motion in joints ___morning stiffness ___neck pain
___nausea ___vomiting ___fever ___chills ___chest pain ___shortness of breath
___calf pain ___thigh pain ___abdominal pain ___diarrhea ___eye problems
___ear problems ___nose problems ___throat problems ___headache/migraines
___thick or discolored toenails ___thick or discolored fingernails ___dry skin ___skin itching
___skin cracking ___skin cancer (type?)_____ ___skin rash
___tingling in feet/toes ___pins and needles ___numbness ___shooting pain ___radiating pain
___increased sensitivity to touch ___decreased or lack of sensation to touch, cold, or warmth

**Thank you. This extra effort on your part helps us help you!**

**SIGNATURE:**_____**Date:**_____