SUMMIT PODIATRY GROUP

PATIENT INFORMATION (Please Print) Today's Date: _____

(Confidential Information – Important for our Files and Your Health)

Patient Name: _____ DOB: ____/____/_____

Social Security Number _____-_____-_____ Age: _____ Gender: ( ) Male ( ) Female

Mailing Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Patient is: ( ) Single ( ) Married ( ) Widowed ( ) Divorced ( ) Partnered

Race:( )White ( )African American ( )American Indian ( )Asian ( )Polynesian ( )Other

Ethnicity:( )Hispanic/Latino ( )Non-Hispanic or Latino

If Minor, Parents Name/Contact Information: _____

How Can We Contact You? (check all that apply) ( ) home ( ) work ( ) cell ( ) by email

Do we have permission: Leave a message on your answering machine ( ) Yes ( ) No

Discuss your medical condition w/any member of your household ( ) Yes ( )No

If Yes, Whom? _____ Relationship: _____

INSURANCE INFORMATION: (Please present insurance card(s) at the time of check-in)

Insurance Co. Name: _____

Name of Subscriber: _____ Subscriber's DOB: ____/____/_____

INSURANCE ASSIGNMENT AND RELEASE

I CERTIFY THAT I HAVE COVERAGE WITH THE ABOVE NAMES INSURANCE AND ASSIGN DIRECTLY TO SUMMIT PODIATRY GROUP ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I AUTHORIZE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. THE ABOVE NAMED PROVIDER MAY USE MY HEALTHCARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE NAMED INSURANCE COMPANY AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DERTERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

TREATMENT CONSENT

I HERBYCONSENT AND GIVE MY PERMISSION TO THE DOCTOR (AND THE DOCTOR'S ASSISTANTS OR DESIGNATED REPLACEMENT) TO ADMINISTER AND PERFORM SUCH PROCEDURES UPON ME AS THE DOCTOR DEEMS NECESSARY.

SIGNATURE OF PATIENT/GUARDIAN_____

EMERGENCY CONTACT:

Name: _____ Phone: _____ Relationship to Patient:_____

EMPLOYMENT: ( ) unemployed ( ) currently employed ( ) retired ( ) on disability

Name of Employer:_____

PRIMARY PHYSICIAN: _____

PHARMACY NAME AND LOCATION:_____

MEDICAL HISTORY HEALTH FORM

Reason For Visit: _____ SHOE SIZE: _____

ALLERGIES: ( ) I AM NOT ALLERGIC TO ANYTHING TO MY KNOWLEDGE.

( ) I AM ALLERGIC TO: _____

MEDICATIONS: _____

SOCIAL HISTORY:

Do you drink alcohol? Yes / No _____ drinks per day/week/month

Do you smoke? Yes / No _____ packs/day Quit, year: _____

Do you use illicit drugs Yes / No _____

Do you have and advanced directive Yes/ No

FAMILY HISTORY: DIABETES _____ FAMILY MEMBER_____

HEART DISEASE _____ FAMILY MEMBER _____

CANCER ____ FAMILY MEMBER _____

SURGICAL HISTORY (Please list past surgeries): _____

_____

Complications with surgery/anesthesia? (please explain) _____

REVIEW OF SYSTEMS: (PLEASE CHECK):

PLEASE MARK IF YOU HAVE HAD OR ARE EXPERIENCING ANY OF THE FOLLOWING

- ○ AIDS/HIV
- ○ ANEMIA
- ○ ANGINA
- ○ ARTHRITIS
- ○ ARTIFICAL HEART VALVES OR JOINTS
- ○ ASTHMA
- ○ BACK PROBLEMS
- ○ CANCER (SPECIFY)_____
- ○ CATARACTS/GLAUCOMA
- ○ LUPUS
- ○ CIRCULATORY PROBLEMS
- ○ DEPRESSION/ANXIETY
- ○ DIABETES TYPE I OR II
- ○ DIGESTIVE PROBLEMS
- ○ HEARING PROBLEMS
- ○ EPILEPSY
- ○ FOOT/LEG CRAMPS
- ○ GOUT
- ○ HEADACHES/MIGRAINES
- ○ HEART DISEASE
- ○ HEPATITIS A, B, C
- ○ HIGH BLOOD PRESSURE
- ○ JAUNDICE
- ○ KIDNEY PROBLEMS
- ○ LIVER DISEASE
- ○ RHEUMATOID ARTHRITIS
- ○ NEUROPATHY
- ○ PHLEBITIS
- ○ PSYCHIATRIC CARE _____
- ○ RESPIRATORY DISEASE
- ○ SINUS PROBLEMS
- ○ STOMACH ULCERS
- ○ STROKE
- ○ SWELLING IN ANKLES/FEET
- ○ TUBERCULOSIS
- ○ ULCERS(SKIN)
- ○ VARICOSE VEINS