

# AFFILIATED PODIATRISTS, LTD.



Drs. Marc Feder • Jason Kalk • David Kretch • Jacob Richey

## WELCOME TO OUR OFFICE

NAME \_\_\_\_\_  
LAST FIRST

ADDRESS \_\_\_\_\_  
STREET APT # CITY STATE ZIP

HOME PHONE (\_\_\_\_) \_\_\_\_\_ CELL (\_\_\_\_) \_\_\_\_\_ WORK (\_\_\_\_) \_\_\_\_\_

AGE \_\_\_\_ BIRTHDATE \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

SEX (circle) M F HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ SHOE SIZE \_\_\_\_\_

YOUR OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_  
NAME RELATIONSHIP PHONE (\_\_\_\_) \_\_\_\_\_

MARITAL STATUS (circle) S M W D NAME OF SPOUSE/PARTNER \_\_\_\_\_

DO YOU HAVE HEALTH INSURANCE?  YES  NO *if yes, we'll need to copy your card(s).*

IS IT YOUR POLICY?  YES  NO WHOSE POLICY IS IT? \_\_\_\_\_

GUARANTOR (RESPONSIBLE PARTY FOR THIS ACCOUNT OR CUSTODIAL PARENT) *complete if different than above*

NAME \_\_\_\_\_  
RELATIONSHIP PHONE (\_\_\_\_) \_\_\_\_\_

ADDRESS \_\_\_\_\_ GUARANTOR'S BIRTHDATE \_\_\_\_\_

GUARANTOR'S EMPLOYER \_\_\_\_\_  
NAME ADDRESS PHONE (\_\_\_\_) \_\_\_\_\_

• If you did not bring insurance cards with you, all charges will be your responsibility and payable at the time of service. Obtaining required referral forms and treatment pre-certification is the patient's responsibility.

**All unpaid balances and/or denied claims are your responsibility.**

NAME OF PRIMARY INSURANCE \_\_\_\_\_

NAME OF SECONDARY INSURANCE \_\_\_\_\_

NAME OF ADDITIONAL INSURANCE PLANS \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_ LAST VISIT \_\_\_\_\_

PREFERRED PHARMACY \_\_\_\_\_ PHONE/LOCATION \_\_\_\_\_

WHO REFERRED YOU TO OUR CARE? \_\_\_\_\_

● **WHAT IS YOUR FOOT PROBLEM?** \_\_\_\_\_

● **FOR HOW LONG HAVE YOU HAD THE PROBLEM?** \_\_\_\_\_ **HAVE YOU BEEN TREATED FOR IT?**  YES  NO

BY WHOM? \_\_\_\_\_

IS YOUR FOOT PROBLEM THE RESULT OF A WORK-RELATED INJURY?  YES  NO

Past Medical History

Have you ever had any of the following?

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Measles                   | <input type="checkbox"/> Bowel Problems           | <input type="checkbox"/> Fevers over 103°    | <input type="checkbox"/> Prolonged Bleeding           |
| <input type="checkbox"/> Mumps                     | <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Psychological Problems       |
| <input type="checkbox"/> Chickenpox                | <input type="checkbox"/> Cataract                 | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizure                      |
| <input type="checkbox"/> Rheumatic Fever           | <input type="checkbox"/> Cellulitis               | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> AIDS or HIV+              | <input type="checkbox"/> Circulatory Disorders    | <input type="checkbox"/> Hearing Loss        | <input type="checkbox"/> Skin Problems                |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> COPD/Breathing Problems  | <input type="checkbox"/> Hepatitis _____     | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Depression               | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Swelling of Feet/Ankles      |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Balance Problems          | <input type="checkbox"/> Digestion Problems       | <input type="checkbox"/> Migraine Headaches  | <input type="checkbox"/> Thyroid Disease              |
| <input type="checkbox"/> Bladder Problems          | <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Numbness/Tingling   | <input type="checkbox"/> Transplant                   |
| <input type="checkbox"/> Blood/Plasma Transfusions | <input type="checkbox"/> Ear/Nose/Throat Problems | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Ulcer Stomach/Skin           |
|  | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Varicose Veins               |
|  | <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Polio               | <input type="checkbox"/> Vision Problems              |
|  |   |  | <input type="checkbox"/> Other _____                  |

Previous Hospitalizations/Surgeries/Serious Illness (and When?) \_\_\_\_\_

What medications &/or vitamins are you taking now and what dose? \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Are you taking Birth Control Pills?  Yes  No

Are you under the care of a physician?  Yes  No If yes, for what reason(s)? \_\_\_\_\_

Social History

Do you live alone?  Yes  No For how long? \_\_\_\_\_

Do you have children?  Yes  No If yes, how many? \_\_\_\_\_

Do you exercise?  Yes  No If yes, how often? \_\_\_\_\_ What kind of exercise? \_\_\_\_\_

Are you on a special diet?  Yes  No If yes, what kind? \_\_\_\_\_

Do you smoke?  Yes  No If yes, how many packs per day? # \_\_\_\_\_ for # \_\_\_\_\_ years.

If former smoker, when did you quit? \_\_\_\_\_ How many packs had you smoked? # \_\_\_\_\_ per day for # \_\_\_\_\_ years.

Do you drink alcohol?  Yes  No How much \_\_\_\_\_ Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly \_\_\_\_\_ Yearly \_\_\_\_\_

Do you have a history of substance abuse?  Yes  No What substance(s)? \_\_\_\_\_

## Medical Information

### Family History

Has anyone in your family ever been diagnosed with the following? Name the relationship next to the condition in the space provided.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Heart Disease _____         | <input type="checkbox"/> Cancer _____       | <input type="checkbox"/> Diabetes _____      |
| <input type="checkbox"/> Circulatory Disease _____   | <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Arthritis _____     |
| <input type="checkbox"/> Neurological Problems _____ | <input type="checkbox"/> Skin Disease _____ | <input type="checkbox"/> Foot Problems _____ |

Additional space, if necessary \_\_\_\_\_

### Review of Systems

Please indicate any personal history below, circle:

- |   |   |  |
|---|---|--|
| <p>● <b>Constitutional Symptoms</b></p> <p>Good general health lately ..... No Yes</p> <p>Recent weight change ..... No Yes</p> <p>Fever ..... No Yes</p> <p>Fatigue ..... No Yes</p> <p>● <b>Eyes</b></p> <p>Wear glasses/contact lenses ..... No Yes</p> <p>Blurred or double vision ..... No Yes</p> <p>● <b>Ears/Nose/Mouth/Throat</b></p> <p>Hearing loss ..... No Yes</p> <p>Earaches ..... No Yes</p> <p>Ringing in ears ..... No Yes</p> <p>Sinus problem ..... No Yes</p> <p>Nose bleeds ..... No Yes</p> <p>Swollen glands in neck ..... No Yes</p> <p>● <b>Cardiovascular</b></p> <p>Chest pain or angina ..... No Yes</p> <p>Swelling of feet, ankles or hands .... No Yes</p> <p>● <b>Respiratory</b></p> <p>Chronic or frequent coughs ..... No Yes</p> <p>Shortness of breath ..... No Yes</p> | <p>● <b>Gastrointestinal</b></p> <p>Loss of appetite ..... No Yes</p> <p>Nausea or vomiting ..... No Yes</p> <p>Diarrhea ..... No Yes</p> <p>Constipation ..... No Yes</p> <p>Blood in stool ..... No Yes</p> <p>Abdominal pain ..... No Yes</p> <p>● <b>Genitourinary</b></p> <p>Frequent urination ..... No Yes</p> <p>Burning or painful urination ..... No Yes</p> <p>Blood in urine ..... No Yes</p> <p>Incontinence or dribbling ..... No Yes</p> <p>● <b>Musculoskeletal</b></p> <p>Joint pain ..... No Yes</p> <p>Joint stiffness or swelling ..... No Yes</p> <p>Muscle pain or cramps ..... No Yes</p> <p>Back pain ..... No Yes</p> <p>Cold extremities ..... No Yes</p> <p>Difficulty in walking ..... No Yes</p> <p>● <b>Integumentary (skin, breast)</b></p> <p>Rash or itching ..... No Yes</p> <p>Change in skin color ..... No Yes</p> <p>Change in hair or nails ..... No Yes</p> | <p>● <b>Neurological</b></p> <p>Headaches ..... No Yes</p> <p>Lightheaded or dizzy ..... No Yes</p> <p>Convulsions or seizures ..... No Yes</p> <p>Numbness or tingling sensations ... No Yes</p> <p>Tremors ..... No Yes</p> <p>Paralysis or weakness ..... No Yes</p> <p>● <b>Psychiatric</b></p> <p>Memory loss or confusion ..... No Yes</p> <p>Nervousness ..... No Yes</p> <p>Depression ..... No Yes</p> <p>Insomnia ..... No Yes</p> <p>● <b>Endocrine</b></p> <p>Excessive thirst or urination ..... No Yes</p> <p>Heat or cold intolerance ..... No Yes</p> <p>Skin becoming drier ..... No Yes</p> <p>● <b>Hematologic/Lymphatic</b></p> <p>Slow to heal after cuts ..... No Yes</p> <p>Bleeding or bruising tendency ..... No Yes</p> <p>Phlebitis ..... No Yes</p> <p>Past transfusion ..... No Yes</p> |
|---|---|--|

### Allergies

Do you have a history of skin reaction or other adverse reaction to:

- |   |   |   |                                  |
|---|---|---|----------------------------------|
| <input type="checkbox"/> Anesthetics    | <input type="checkbox"/> Codeine                  | <input type="checkbox"/> IV Dye             | <input type="checkbox"/> Silver  |
| <input type="checkbox"/> Animals/Dander | <input type="checkbox"/> Environmental Substances | <input type="checkbox"/> Pain Medication    | <input type="checkbox"/> Sulfa   |
| <input type="checkbox"/> Antibiotics    | <input type="checkbox"/> Foods                    | <input type="checkbox"/> Penicillin         | <input type="checkbox"/> Tape    |
| <input type="checkbox"/> Aspirin        | <input type="checkbox"/> Iodine                   | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Tetanus |

Specify above and list any others: \_\_\_\_\_

To the best of my knowledge, the above information that I have submitted is correct. I understand that giving incorrect information can be dangerous to my health. It is my responsibility to inform the doctors' office of any changes in my medical status. I, hereby, give my permission to the Doctors of AFFILIATED PODIATRISTS to diagnose and administer treatment of my foot condition.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Reviewed by: \_\_\_\_\_

# AFFILIATED PODIATRISTS, LTD.



## PATIENT AGREEMENTS AND AUTHORIZATIONS

**CONSENT FOR TREATMENT.** I hereby consent to the treatment provided by Affiliated Podiatrists, Ltd. and its employees or designees. I authorize the physical health care services deemed necessary or advisable by my caregivers to address my needs. \_\_\_\_\_  
(initial)

**CONSENT FOR PHOTOGRAPHS.** I grant permission for photographs to be taken to assist in documenting my condition. \_\_\_\_\_  
(initial)

### **AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION.**

I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the Practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Practice may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. \_\_\_\_\_  
(initial)

### **ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE.**

I authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to the Practice for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney's fees.

\_\_\_\_\_  
(initial)

**PRIVACY POLICY.** I acknowledge having received the Practice's "Notice of Privacy Policies". My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the Practice has already made disclosures with my prior consent. \_\_\_\_\_  
(initial)

**CANCELLATION POLICY.** I understand that if I am unable to keep an appointment, I must give at least a 24 hour notice so that another patient might be able to use my reserved time. In the event that I don't give advance notice, I will incur a "no show" or "last minute" cancellation fee of \$95. \_\_\_\_\_  
(initial)

\_\_\_\_\_  
Patient or Authorized Person Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date