PODIATRIC REGISTRATION AND HISTORY

Date:_____

Email:_____

Patient:_____

Address:_____

_____
City State Zip

Sex:____ Age:____ Birthdate:_____

_____
Patient SS#

_____
Occupation:

Employer:_____

Whom may we thank for referring you?

_____

PHONE NUMBERS
Mobile:_____

Home:_____

IN CASE OF EMERGENCY, CONTACT
Name:_____
Relationship:_____
Phone:_____

Shoe size:_____ Blood Pressure Reading:_____Current weight:_____Height:_____

PRIMARY INSURANCE

Subscriber's Name:_____

Relationship to patient:_____

Insurance Co.: _____

ID #_____

Group #_____

SECONDARY INSURANCE

Subscriber's Name:_____

Relationship to patient:_____

Insurance Co.:_____

ID #_____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Affordable Foot and Leg for all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Responsible Party Signature Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf of Affordable Foot and Leg for any services furnished to me by Dr. Stam. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these

health insurance" is indicated in any electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____

Beneficiary Signature

Podiatric History

Have you ever been to a Podiatrist before? Y__N__ Name _____ Last visit _____
Do you smoke: Y____ N_____ If so, number of packs per day_____
Have you previously smoked Y or N When did you quit_____
How many packs?_____

Athletic activities in which you participate (please list and indicate frequency):
_____
_____
_____

Describe your foot and leg problems and/or symptoms:

1.)_____

How long have you had this problem?_____Days Weeks Months

2.)_____

How long have you had this problem?_____Days Weeks Months

Describe any past problems with your feet or leg:_____
_____

List any past surgical procedures on your feet or leg and approximate dates:

1.)_____ Date:_____

2.)_____ Date:_____

Do you have any allergies?: Y_____ N_____ **if so, list any known allergies and reactions:**
_____
_____
_____

Any problems with local anesthetics (Marcaine, Lidocaine, etc.)? : Y_____ N____

Do you have or have you had any of the following conditions? Y or N

_____High Blood Pressure	_____Arthritis	_____Gout
_____Foot/Leg burning sensation	_____Foot/leg cramps	_____Varicose veins
_____Poor Circulation	_____Visual problems	_____Blood clots
_____Stomach ulcers	_____Anemia	_____Stroke
_____Kidney Disease	_____Skin Problems	_____Cancer
_____Weight loss/gain	_____Asthma	_____Seizures
_____Joint Replacement	_____Night Sweats	_____Cold Feet
_____Foot/Leg Swelling	_____Foot Tingling	_____Lung Disease
_____Aids/HIV	_____Bleeding Disorders	_____Epilepsy
_____Fainting	_____Liver Disease	_____Tired feet
_____Neuropathy	_____Tuberculosis	_____Hepatitis
_____Vein inflammation	_____Osteoporosis	_____Sciatica
_____Psychiatric Care	_____Foot/Leg numbness	_____Heart Disease

Do you have Diabetes? : Y____ N____ **If yes, do you take insulin?** : Y_____N____

When diagnosed_____ Treating physician:_____
Date of last visit:_____ Last blood pressure reading:_____

List any serious illness (last 10 years)_____

List any major surgeries (last 10 years)_____

Are you presently under a physician's care: : Y____ N__
If so, please list the condition being treated and the physician:

Condition:_____ Physician:_____
Do you take any medications? Y_____ N_____ & if so, dosage?_____
_____
_____

Family History:
Any family history of the following diseases? If so, which family member?

Heart Disease	M F B S	Arthritis	M F B S
Cancer	M F B S	Bleeding disorder	M F B S
Diabetes	M F B S	Stroke	M F B S
Neurologic Disorder	M F B S	Circulation problems	M F B S
High Blood Pressure	M F B S	Vascular disorders	M F B S

Consent

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature_____Date _____