AFFILIATED PODIATRISTS, LTD.

Drs. Joel Feder • Marc Feder • Jason Kalk • 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 (____) ____________ FAX (____) ____________

PHYSICIAN'S HOSPITAL AFFILIATION ______________________ DATE OF LAST VISIT ____________

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

Medical Information

Past Medical History

Have you ever had any of the following?

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

☐ Heart Disease ____________ ☐ Cancer ____________ ☐ Diabetes ____________

☐ Circulatory Disease ____________ ☐ Hypertension ____________ ☐ Arthritis ____________

☐ Neurological Problems ____________ ☐ Skin Disease ____________ ☐ Foot Problems ____________

Additional space, if necessary ____

Review of Systems

Please indicate any personal history below, circle:

● Constitutional Symptoms

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes

● Eyes

Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes

● Ears/Nose/Mouth/Throat

Hearing loss	No	Yes
Earaches	No	Yes
Ringing in ears	No	Yes
Sinus problem	No	Yes
Nose bleeds	No	Yes
Swollen glands in neck	No	Yes

● Cardiovascular

Chest pain or angina	No	Yes
Swelling of feet, ankles or hands	No	Yes

● Respiratory

Chronic or frequent coughs	No	Yes
Shortness of breath	No	Yes

● Gastrointestinal

Loss of appetite	No	Yes
Nausea or vomiting	No	Yes
Diarrhea	No	Yes
Constipation	No	Yes
Blood in stool	No	Yes
Abdominal pain	No	Yes

● Genitourinary

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Incontinence or dribbling	No	Yes

● Musculoskeletal

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

● Integumentary (skin, breast)

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes

● Neurological

Headaches	No	Yes
Lightheaded or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis or weakness	No	Yes

● Psychiatric

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

● Endocrine

Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming drier	No	Yes

● Hematologic/Lymphatic

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes

Allergies

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

☐ Anesthetics ☐ Codeine ☐ IV Dye ☐ Silver

☐ Animals/Dander ☐ Environmental Substances ☐ Pain Medication ☐ Sulfa

☐ Antibiotics ☐ Foods ☐ Penicillin ☐ Tape

☐ Aspirin ☐ Iodine ☐ Seasonal Allergies ☐ 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