

Patient Information

Date _____
SS/HIC/Patient ID # _____
Patient Name _____
Last Name _____
First Name _____ Middle Name _____
Address _____
City _____
State _____ Zip _____
Email _____
Sex ☐ M ☐ F Age _____ Birthdate _____
Married Widowed Single Minor
Separated Divorced Partnered for ____ Year
Patient/Employer School _____
Employer/School Address _____
Employer/School Phone (_____) _____
Spouse's Name _____
Birthdate _____ SS# _____
Spouse's Employer _____
Whom may we thank for referring you? _____

Phone Numbers

Home Phone (_____) _____
Cell Phone (_____) _____
Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT
Name _____
Relationship _____
Home Phone (_____) _____
Work Phone (_____) _____

Insurance

Who is responsible for this account? _____
Relationship to patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber's Name _____
Birthdate _____ SS # _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
INSURANCE ASSIGNMENT AND RELEASE
I certify that I have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____

Name of Doctor Or Clinic
To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services. My Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative

Please print name of Beneficiary, Guardian or Personal Representative

Date

Relationship to Beneficiary

Podiatric History

What is the chief complaint for which you came to be treated? (Included tools, ankle, knee, thigh, and hip complaints.)

Have you ever been to a Podiatrist before?

☐ Yes ☐ No

If yes, please list. _____

Is there any personal or family history of diabetes?

☐ Yes ☐ No

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____

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

Shoe size _____ HT _____ WT _____

Please indicate which foot problems you now have or have had in past.

	Yes	No
Ankle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Athlete's Foot	<input type="checkbox"/>	<input type="checkbox"/>
Bunions	<input type="checkbox"/>	<input type="checkbox"/>
Corns and Calluses	<input type="checkbox"/>	<input type="checkbox"/>
Cramps or Numbness in Feet or Legs	<input type="checkbox"/>	<input type="checkbox"/>
Flat Feet	<input type="checkbox"/>	<input type="checkbox"/>
Foot or Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Heel Pain	<input type="checkbox"/>	<input type="checkbox"/>
Ingrown toenails	<input type="checkbox"/>	<input type="checkbox"/>
Plantar Warts	<input type="checkbox"/>	<input type="checkbox"/>

Medical History

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

	Yes	No		Yes	No		Yes	No
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to Medicine or Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Foot or Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valves or Joints	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in Ankles, Feet	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Neck Glands	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tired Feet	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss, unexplained	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>			
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>			

Surgeries you have had _____

Hospitalization other than for the surgeries listed _____

Family physician _____ Last visit date _____

Are you now, or have you been under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain _____

Medications

Include prescription, over-the-counter medications and vitamins _____

Pharmacy Name(s) _____

Pharmacy Phone(s) (_____) _____

Do you take oral contraceptives? ☐ Yes ☐ No

Allergies

- | | |
|--|--|
| <input type="checkbox"/> Adhesive/Tape | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Anticoagulant Therapy | <input type="checkbox"/> Novocaine |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Seafood |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | |

Treatment Consent

I hereby consent and give my permission to the doctor (and the doctor's assistant or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Patient Information

Date _____
SS/HIC/Patient ID # _____
Patient Name _____
Last Name _____
First Name _____ Middle Name _____
Address _____
City _____
State _____ Zip _____
Email _____
Sex ☐ M ☐ F Age _____ Birthdate _____
Married Widowed Single Minor
Separated Divorced Partnered for _____ Year
Patient/Employer School _____
Employer/School Address _____
Employer/School Phone (_____) _____
Spouse's Name _____
Birthdate _____ SS# _____
Spouse's Employer _____
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Relationship to patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber's Name _____
Birthdate _____ SS # _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
INSURANCE ASSIGNMENT AND RELEASE
I certify that I have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ 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 authorize the use of my signature on all insurance submissions.

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Name of Doctor Or Clinic _____
To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services. My Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative _____

Please print name of Beneficiary, Guardian or Personal Representative _____

Date _____

Relationship to Beneficiary _____

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Years smoked _____

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Shoe size _____ HT _____ WT _____
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Athlete's Foot	<input type="checkbox"/>	<input type="checkbox"/>
Bunions	<input type="checkbox"/>	<input type="checkbox"/>
Corns and Calluses	<input type="checkbox"/>	<input type="checkbox"/>
Cramps or Numbness in Feet or Legs	<input type="checkbox"/>	<input type="checkbox"/>
Flat Feet	<input type="checkbox"/>	<input type="checkbox"/>
Foot or Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Heel Pain	<input type="checkbox"/>	<input type="checkbox"/>
Ingrown toenails	<input type="checkbox"/>	<input type="checkbox"/>
Plantar Warts	<input type="checkbox"/>	<input type="checkbox"/>



ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I as provided a copy of the Notice of Privacy Practices and that I read (or had the opportunity to read if I chose) and understood the notice.

Patient Name (Please Print)

Date

Parent or Authorize Representative (if applicable)

Signature

INFORMATION PERSONAL

Apellido _____ Nombre _____ Inicial _____ MF
Fecha de Nacimiento ____/____/____ Numero de Seguro Social ____-____-____
Direccion _____
Ciudad _____ Estado _____Codigo Postal _____ Tel (____) ____-____
Empleado _____ Tel (____) ____-____
Direccion _____ Ciudad _____ Estado _____Codigo Postal _____

INFORMATION DE ASEGURANZA

1)
Nombre de Aseguranza _____
Numero de ID _____ Numero de Grupo _____
Nombre de Responsable _____
Fecha de Nacimiento ____/____/____ Seguro Social ____-____-____
Empleado _____ Tel (____) ____-____
Direccion _____ Ciudad _____ Estado _____Codigo Postal _____
2)
Nombre de
Aseguranza _____
Numero de ID _____ Numero de Grupo _____
Nombre de Responsable _____
Fecha de Nacimiento ____/____/____ Seguro Social ____-____-____
Empleado _____ Tel (____) ____-____
Direccion _____ Ciudad _____ Estado _____Codigo Postal _____

EN CASO DE EMERGENCIA

Nombre _____ Relacion con Paciente _____
Direccion _____ Ciudad _____ Estado _____Codigo Postal _____
Tel (____) ____-____

Estoy de acuerdo en aceptar la responsabilidad rentistica por los servicios al
paciente y autoizar pagos deprete de cualquier tipo de beneficio medico al Dr. Bledsoe

Firma del Paciente o Responsable _____

Fecha _____