

PATIENT INFORMATION AND HISTORY

<p><u>PATIENT INFORMATION</u></p> <p>DATE _____ SS# _____</p> <p>Patient Name: _____</p> <p>Address: _____</p> <p>City/State/Zip _____</p> <p>Date of Birth: _____ Male/ Female _____</p> <p style="padding-left: 20px;"> <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow </p> <p>Is the patient a full time student?: _____</p> <p>Employer _____</p> <p>Work phone # _____</p> <p>Spouse's Name _____</p> <p>Employer _____ WK# _____</p> <p><u>How were you referred to our office? (Ex: dr., ins, patient, sign, phone book)</u></p> <p>_____</p>	<p><u>INSURANCE ASSIGNMENT AND RELEASE</u></p> <p>I, the undersigned, certify that I (or my dependent) have insurance coverage with _____</p> <p style="text-align: center; font-size: small;">(NAME OF INSURANCE COMPANY)</p> <p>and assign directly to James Whitfield, DPM all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for costs not covered or reimbursed by third party payors. I authorize the use of this signature on all insurance submissions and certify that the information provided here is true and correct.</p> <p>James Whitfield, DPM, 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 relates services. The consent will end when my current treatment plan is completed or one year from the date signed below.</p>
<p><u>PHONE NUMBERS</u></p> <p>Patient Home #: _____ Cell/Alternate : _____</p> <p>IN CASE OF EMERGENCY, CONTACT:</p> <p>Name _____</p> <p>Relationship to patient _____</p> <p>Home # _____ WK # _____</p>	<p><u>MEDICARE AUTHORIZATION</u></p> <p>I authorize the Social Security Administration to disclose information regarding my Medicare coverage, including but not limited to, verification or my Medicare number, effective dates, and type of coverage.</p> <p>The understand certifies that he/she has read the foregoing and is the patient, or is duly authorized by that patient as patient's general agent to execute the above and accept its terms. It is further understood that this release remains in effect for one (1) year unless otherwise revoked.</p>
<p><u>PERSON RESPONSIBLE FOR THIS ACCOUNT</u> <small>(IF DIFFERENT FROM PATIENT)</small></p> <p>Name: _____</p> <p>Relationship to patient: _____</p> <p>Address _____</p> <p>City/State/Zip _____</p> <p>Home # _____ WK# _____</p>	<p>_____</p> <p>SIGNATURE OF PATIENT/GUARDIAN/PERSONAL REP.</p> <p>_____</p> <p>PLEASE PRINT NAME OF ABOVE SIGNATURE</p> <p>_____</p> <p>DATE _____ RELATIONSHIP TO PATIENT _____</p>
<p><u>INSURANCE INFORMATION</u></p> <p>PRIMARY INSURANCE</p> <p>Name of Insured: _____</p> <p>Date of birth: _____ Relationship to patient _____</p> <p>Insurance Name _____</p> <p>Insured's ID # _____ Group/Policy # _____</p> <p>Insured's Employer _____</p> <p>Secondary Insurance (If applicable)</p> <p>Name of Insured: _____</p> <p>Date of birth _____ Relationship to patient _____</p> <p>Insurance Name _____</p> <p>Insured's ID# _____ Group # _____</p> <p>Insured's Employer _____</p>	<p>_____</p> <p>DATE _____ RELATIONSHIP TO PATIENT _____</p>

Patient Name: _____

My foot problem is: _____ how long? _____

Prior or self-treatment for this problem: _____

MEDICAL HISTORY			
Circle any condition YOU currently have or have had:			
Anemia	Ear/hearing problem	HIV (AIDS)	Nerve Pain
Asthma	Epilepsy	Kidney/Urine problems	Phlebitis
Arthritis	Fever	Leg Cramps	Poor Vision/Eye problems
Allergies (seasonal)	Gout	Liver problem	Sickle Cell Anemia
Artificial Joints	Heart problems	Low Back problems	Stomach Ulcers/ problems
Bleeder	Heart Valve Implant	Mental/Emotional problems	Stroke
Chest pains	Hepatitis	Muscle Pain	Tuberculosis
Cancer	High Blood Pressure	Neurological/Muscular problems	Unequal Leg Length
Diabetes YES NO			Varicose Veins
Insulin? YES NO			
<i>If DIABETIC, doctor treating diabetes:</i>			
Dr. Name _____ Phone # _____ Last date seen _____			

MEDICATIONS	
List any prescriptions, over-the-counter, and vitamins	

ALLERGIES	
List any allergies (ex: penicillin, tape, etc..)	

ADDITIONAL HISTORY			
Do you smoke? Yes No	If yes, amount:	List any surgeries/hospitalization in last 5 years	
Do you drink alcohol? Yes No	If yes, amount:		
What is your Height: _____ Weight: _____ Shoe size: _____			
Name of Family Doctor: _____			
Dr. phone number: _____		Last date seen: _____	

Circle YES or NO to report your FAMILY HISTORY (blood relatives)			
RELATIVE:		RELATIVE:	
Diabetes YES NO		Flat Feet YES NO	
Cancer YES NO		Tuberculosis YES NO	
Bleeder YES NO		High Blood Pressure YES NO	
Hepatitis YES NO		HIV (AIDS) YES NO	
Bunions YES NO		Heart Problem/Stroke YES NO	
Hammertoes YES NO		Circulation Problem Leg/Feet YES NO	

TREATMENT CONSENT	
I hereby consent 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, Parent, Guardian, or Personal Representative _____	Date _____
Please Print above Signature _____	