WELCOME

PATIENT INFORMATION:

Date: _____

Patient Name: _____

Social Security #: _____

Address: _____

_____

Email: _____

Sex: □ Male □ Female Age: _____ Birthdate: _____

□ Married □ Separated □ Widowed □ Single

□ Divorced □ Minor □ Partnered for ___ years

Patient Employer/School: _____

Employer/School Address: _____

_____

Spouse's Name: _____

Birthdate: _____ Social Security #: _____

Spouse's Employer: _____

Who 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: ( ) _____

PODIATRIC HISTORY:

What is the chief complaint for which you came to be treated?

_____

_____

_____

Have you ever been to a podiatrist before? □ Yes □ No
If yes, please list: _____ Last visit: _____
Is there any personal or family history of diabetes? □ Yes □ No
Your occupation: _____
Cigarette/tobacco use: □ Yes □ No □ Quit ____ years ago
Years smoked: _____
Alcohol use: □ social □ rare □ occasional □ daily
Athletic activities in which you participate (please list and indicate frequency): _____

_____

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

Ankle pain	□ Now	□ Past	□ Never
Athlete's foot	□ Now	□ Past	□ Never
Bunions	□ Now	□ Past	□ Never
Corns and Callouses	□ Now	□ Past	□ Never
Cramps in feet/legs	□ Now	□ Past	□ Never
Flat feet	□ Now	□ Past	□ Never
Gout	□ Now	□ Past	□ Never
Heel pain	□ Now	□ Past	□ Never
Ingrown toenails	□ Now	□ Past	□ Never
Numbness in feet/legs	□ Now	□ Past	□ Never
Plantar warts	□ Now	□ Past	□ Never
Swelling in feet/legs	□ Now	□ Past	□ Never
Tired feet	□ Now	□ Past	□ Never

ALLERGIES:

□ Adhesive tape	□ Demerol	□ Penicillin
□ Aspirin	□ Iodine	□ Seafoods
□ Blood thinners	□ Local anesthetics	□ Sulfa
□ Codeine	□ Novocaine	

□ Other: _____

MEDICATIONS:

Include prescriptions, over-the-counter medications, and vitamins:

_____

_____

_____

_____

Pharmacy Name: _____

Phone Number: ( ) _____

Pharmacy Address: _____

_____

Do you take oral contraceptives? □ Yes □ No

MEDICAL HISTORY:

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

AIDS/HIV	□ Now	□ Past	□ Never
Allergies to anesthetics	□ Now	□ Past	□ Never
Allergies to medicine/drugs	□ Now	□ Past	□ Never
Anemia	□ Now	□ Past	□ Never
Angina	□ Now	□ Past	□ Never
Arthritis	□ Now	□ Past	□ Never
Artificial valves/joints	□ Now	□ Past	□ Never
Asthma	□ Now	□ Past	□ Never
Back problems	□ Now	□ Past	□ Never
Bleeding disorders	□ Now	□ Past	□ Never

Cancer □ Now □ Past □ Never
Chemical dependency □ Now □ Past □ Never
Chest pain □ Now □ Past □ Never
Chronic diarrhea □ Now □ Past □ Never
Diabetes □ Now □ Past □ Never
Year diagnosed: _____
Pills only: □ Yes Insulin: □ Yes (year started_____)
Ear problems □ Now □ Past □ Never
Epilepsy □ Now □ Past □ Never
Eye problems □ Now □ Past □ Never
Fainting □ Now □ Past □ Never
Headaches □ Now □ Past □ Never
Heart disease □ Now □ Past □ Never
Hemophilia □ Now □ Past □ Never
Hepatitis □ Now □ Past □ Never
High blood pressure □ Now □ Past □ Never
Jaundice □ Now □ Past □ Never
Kidney problems □ Now □ Past □ Never
Liver disease □ Now □ Past □ Never
Low blood pressure □ Now □ Past □ Never
Lung disease □ Now □ Past □ Never
Neuropathy □ Now □ Past □ Never
Phlebitis □ Now □ Past □ Never
Psychiatric care □ Now □ Past □ Never
Radiation treatment □ Now □ Past □ Never
Rash □ Now □ Past □ Never
Rheumatic fever □ Now □ Past □ Never
Shortness of breath □ Now □ Past □ Never
Sinus problems □ Now □ Past □ Never
Special diet □ Now □ Past □ Never
(what kind: _____)
Stroke (year: _____) □ Now □ Past □ Never
(which side of your body was affected? _____)
Swollen neck glands □ Now □ Past □ Never

Tuberculosis	□ Now	□ Past	□ Never
Ulcers (stomach)	□ Now	□ Past	□ Never
Varicose veins	□ Now	□ Past	□ Never
Venereal disease	□ Now	□ Past	□ Never
Weight loss, unexplained	□ Now	□ Past	□ Never

Surgeries you have had:

_____

_____

_____

Hospitalizations 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 during the past two years? □ Yes □ No

If yes, explain:

_____

_____

TREATMENT CONSENT:

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

_____

Signature of patient, parent, guardian or personal representative

_____

Please print name of patient, guardian, or personal representative

_____ _____

Relationship to patient if guardian/representative Date

INSURANCE:

Who (person) is responsible for this account? _____
Relationship to patient: _____
Insurance company: _____
ID #: _____ Group #: _____
Subscriber's name_____
Subscriber's birthdate: _____
Subscriber's social security number: _____
Relationship to patient: _____
Is patient covered by additional insurance? □ Yes □ No
If yes, please list below:
(Secondary) Insurance company: _____
ID #: _____ Group #: _____
Subscriber's name_____
Subscriber's birthdate: _____
Subscriber's social security number: _____
Relationship to patient: _____

Insurance assignment and release:

I certify that I have coverage with _____
(Name of insurance company/ies)
and assign directly to Dr. Miller-Khawam of A Step Above Foot Care 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 is an ongoing consent, with no termination date.

Signed: _____ Date: _____

Print name: _____

Medicare/Medi-gap Authorization:

I request that payment of authorized Medicare benefits and, if applicable, Medi-gap benefits, be made to Dr. Miller-Khawam at A Step Above Foot Care for any services furnished to me by that provider.

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 Medi-gap 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

_____ _____

Relationship to beneficiary if guardian/representative Date