Patient Information

Last Name:	**First Name:**	**Middle Name:**
Sex: ☐ F ☐ M	**DOB:**	**SSN:**
Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Home Phone#:	**Cell Phone#:**	
Work Phone#:	**Emai**	
Physical Address:		
City:	**State:**	**Zip:**
☐ **Mailing Address same as Physical Address**		
Mailing Address:		
City:	**State:**	**Zip:**

Primary Physicians Name:	**Phone#:**
Pharmacy Name:	**Phone#:**

Emergency Contact

Emergency Contact Name:	
Phone#:	**Relationship:**

Employment

Status: ☐ Student ☐ Employed ☐ Unemployed ☐ Retired	
Occupation:	**Employer:**

Insurance Information

Primary Insurance:	
Subscriber Name:	☐ M ☐ F
Subscriber DOB:	**Subscriber SSN:**
Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other	**Insurance Phone#:**
Member ID #:	**Group ID #:**
Secondary Insurance:	
Subscriber Name:	☐ M ☐ F
Subscriber DOB:	**Subscriber SSN:**
Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other	
Insurance Phone#:	
Member ID #:	**Group ID #:**

I hereby authorize Total Podiatry to release medical information pertinent to the filing of insurance claims for me. I authorize my insurance carrier to pay benefits directly to Total Podiatry on any unpaid services filed on my behalf. I understand that **I AM FINANCIALLY RESPONSIBLE** for all charges, whether paid by insurance or not, and for all services rendered on my behalf or my dependents. I understand that I am financially responsible for any collection fee should I default on any patient balances. I also understand that Total Podiatry is not ultimately responsible for collecting my insurance or negotiating settlements of claims. I authorize Total Podiatry to release the information required to secure the payment or benefits. I authorize the use of the signature on all insurance submissions.

Signature of Responsible Party: ____ Date: ________________

History of Present Illness / What brings you in?

What is your specific foot/ankle problem?	Which foot/ankle is involved? ☐ Right ☐ Left ☐ Both
	First visit to a doctor for this problem? ☐ Yes ☐ No
	Have you had a similar problem in the past? ☐ Yes ☐ No
When did the problem begin?	How was the problem onset? ☐ Sudden ☐ Gradual

The problem is worst: ☐ AM ☐ PM ☐ At Rest ☐ With Activity

Is the problem painful? ☐ Yes ☐ No Is so, rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing ☐ Cramping ☐ Itching ☐ Popping ☐ Burning ☐ Tingling ☐ Clicking ☐ Shooting ☐ Stabbing ☐ Other

Have you experienced any trauma or injury to the area? ☐ Yes ☐ No If so, is it work-related? ☐ Yes ☐ No

History and Physical

Height:	Weight:	Shoe size:

List of Medications:

Allergies: ☐ None ☐ Adhesives/Tape ☐ Aspirin ☐ Codeine ☐ Cortisone ☐ Iodine ☐ Latex ☐ Local Anesthetics ☐ Penicillin ☐ Seafood/Shellfish ☐Sulfa Drugs ☐ Other

Social History

Do you drink alcohol? ☐No ☐ Rarely ☐Socially ☐ Everyday

Do you drink caffeinated beverages? ☐ No ☐ Yes **How much?**

☐ **I use or have used Tabaco Products**	**Type:**	
Packs/ Day:	**Years:**	**When stopped?**
I stand % of my day	**I exercise each week:** ☐ 0 days ☐ 1-2 days ☐ 3+ days	

List Sports/Activities:

☐ **My foo/ankle problem limits my activities**

Medical History

☐ Diabetes Type:	☐ Gout	☐ Neuropathy
☐ Acid Reflux	☐ Healing Problems/ Keloids	☐ Osteomyelitis/Bone Infection
☐ Anemia	☐ Heart Disease/Heart Attack	☐ Parkinson's Disease
☐ Anesthesia complications	☐ High blood Pressure (☐ Low BP?)	☐ Previous Addiction to:
☐ Arthritis (☐ Osteo / ☐ Rheum)	☐ High Cholesterol	☐ Pulmonary Embolism
☐ Asthma	☐ Hormone Therapy	☐ Rashes/Skin Condition
☐ Blood Clot/ DVT	☐ Immune Disorder/HIV	☐ Raynaud's Disease/Phenomena
☐ Cancer:	☐ Kidney disease (☐ Dialysis)	☐ Seizure Disorder/Epilepsy
☐ Cellulitis/Skin infection (☐ MRSA?)	☐ Liver Disease (☐Hepatitis)	☐ Sickle Cell Disease/Trait
☐ Circulation Problems	☐ Leg cramps/Leg pain at Rest	☐ Sleep Apnea
☐ Dementia/Alzheimer's	☐ Lung Condition:	☐ Stomach Ulcers
☐ Excessive/Easy Bleeding	☐ Mitral Valve Prolapse/Murmur	☐ Stroke ☐ RT ☐ LT (year)
☐ Fibromyalgia	☐ Multiple Sclerosis	☐ Thyroid Condition (☐ Hi ☐ Lo)
☐ Foot/Leg Ulcer	☐ Nervous Disorder/Depression	☐ Varicose Veins
☐ Other problems not listed:	☐ Pregnant	☐ Breast Feeding

Past Surgeries

☐ Foot/Ankle Surgery:	☐ Stent Replacement: Heart Leg (circle one)
☐ Joint Replacement:	☐ Cosmetic Surgery:
☐Open Heart / Bypass Surgery	☐ Appendix ☐ Gallbladder ☐ Tonsils/Add
☐ Hysterectomy ☐ Tubal ligation ☐ C- Section	☐ Leg Bypass ☐ Open Fracture repair
☐ Carotid Surgery ☐ Vein Surgery	☐ Hernia repair ☐ Thyroid ☐ Back Surgery
☐ Other:	

Family History

M - Mother | **F –** Father | **S -** Sister | **B -** Brother | **GP** - Grandparent

☐ Cancer	M	F	S	B	GP	☐ Kidney Disease	M	F	S	B	GP
☐ Diabetes	M	F	S	B	GP	☐ Liver Disease	M	F	S	B	GP
☐ Blood Clot	M	F	S	B	GP	☐ Foot Problems	M	F	S	B	GP
☐ Heart Disease	M	F	S	B	GP	☐ Other:	M	F	S	B	GP
☐ High Blood Pressure	M	F	S	B	GP						

Review of Systems: **(Please check the box if you currently have any of these symptoms or check "NONE")**

Cardiovascular	☐ Ankle Swelling ☐ Cold Feet/ Hands	☐ Leg Pain ☐ Leg Swelling	☐ Palpitations ☐ Vascular Disease	☐ NONE
Gastrointestinal	☐ Abdominal Pain ☐ Blood in Stool ☐ Constipation	☐ Decreased Appetite ☐ Diarrhea	☐ Heartburn ☐ Vomiting ☐ Ulcers	☐ NONE
Genitourinary	☐ Blood in Urine ☐ Decreased Urination	☐ Excessive Urination ☐ Kidney stones	☐ Incontinence ☐ Painful urination	☐ NONE
Integumentary	☐ Athletes Foot ☐ Callus/Corns ☐ Cracked Heels	☐ Ingrown Toenail ☐ Keloids ☐ Nail Changes	☐ Nail Fungus ☐ Ulcers ☐Warts	☐ NONE
Musculoskeletal	☐ Ankle pain ☐ Arch pain ☐ Ball pain	☐ Bottoms of Foot pain ☐ Flat Feet	☐ Heel Pain ☐ Toe Pain ☐ Top of Foot Pain	☐ NONE
Neurological	☐ Numbness ☐ Paralysis	☐ Seizures ☐ Tingling/Burning	☐ Tremors ☐ Weakness	☐ NONE
Respiratory	☐ Chest Pain ☐ COPD	☐ Coughing ☐ Shortness of Breath	☐ Wheezing	☐ NONE

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I AM RESPONSIBLE for notifying the physician and/or medical staff of any and all updates to the information listed above.

Signature of Responsible Party: ____ Date: ________________

NOTICE OF PRIVACY PRACTICE

Patient Name: ____ Date of Birth: ________________

I have been provided with a copy of the "Notice of Privacy Practices."

Patient Signature/Representative: ____

Please list below the names, relationship, and phone number of any authorized individuals (spouse, family members, friends, caregivers, etc.) that we may discuss your medical or financial information with.

Name Relationship Phone Number

1. ____

2. ____

3. ____

Patient Signature/Representative: ___________________________________ Date: __________________

OR

If you do not want any of your medical or financial information discussed with anyone other than yourself, please sign below.

Patient Signature/Representative: ___________________________________ Date: __________________

THE ABOVE INFORMTION IS PRIVATE AND CONFIDENTIAL

AND WILL BE PLACED IN YOUR CHART.

CONSENT TO EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDER

AND OTHER HEALTHCARE COMMUNICATIONS

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

__________ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information to the following Cell Phone number: ____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Signature: ____

Name: ____

Date: ____

NO SHOW/MISSED APPOINTMENT POLICY

We, at Total Podiatry, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the office.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one to two business days prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

Please review the following policy:

1. Please cancel your appointment with at least 24 hours' notice: There is a waiting list to see the providers at Total Podiatry and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

2. If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment.

3. If you do not present to the office for our appointment, this will be documented as a "No-Show" appointment.

4. After the first "No-Show/Missed" appointment, you will receive a phone call or letter warning that you have broken our "No-Show" Policy. Total Podiatry will assist you to reschedule this appointment if needed.

5. A $25 no show fee will be applied to every "No-Show/Missed" appointment if you have 2 or more.

I have read and understand Total Podiatry No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Total Podiatry appropriately if I have difficulty keeping my scheduled appointments.

______________________________________ ______________ ________________

Patient Name Date of Birth Date

______________________________________ __________________________

Patient Signature or Parent/Guardian if minor Relationship to Patient

Authorization and Release of Multimedia Images and Filming Information

I consent for medical imaging (photo, video, and/or audio) to be made of me or my child (or for person whom I am legal guardian) on behalf of Total Podiatry may be used in connection with publicizing and promoting Total Podiatry. I authorize Total Podiatry to use my name, brief biographical information, and the medical images as defined on this form.

I hereby irrevocably authorize Total Podiatry to copy, exhibit, publish or distribute the medical images for purposes of publicizing Total Podiatry services or for any other lawful purpose. These statements may be used in printed publications, multimedia presentations, on websites or in any other distribution media. I agree that I will make no monetary or other claim against Total Podiatry for the use of the statement.

In addition, I waive any right to inspect or approve the finished product, including written copy wherein my testimonial appears.

I hereby hold harmless and release Total Podiatry from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I have read the authorization and release information and give my consent for the use of my testimonial as indicated above.

Print Name: ______________________________

Signature: ______________________________

Date: ______________________________

Email: ______________________________

Address: ______________________________

City, State, Zip: ______________________________