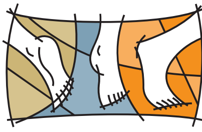

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PATIENT ACCT.# ______ CHART ______

PATIENT INFORMATION

Name: ______________________________ Date of birth:_____/_____/_____
First Middle Last

Home phone: ( ) ______________ FAX : ( ) ______________

Work phone: ( ) ______________ Ext.:________ Cell phone: ( )__________

Address: ______________________________
Street City State ZIP

E-mail address: ______________________________

Social Security #: ______________ Sex: ❐ M ❐ F

Referring doctor: ______________________________

Pharmacy & phone #: ______________________________

Other referring source: ❐ Advertisement ❐ Family/friend ❐ Insurance ❐ Newspaper ❐ Phone book ❐ Other

PATIENT EMPLOYER INFORMATION

Patient's employer name: ______________________________

Address: ______________________________
Street City State ZIP

Patient's occupation: ______________ Contact person (at work): ______________

Contact phone: ( ) ______________ Fax: ( ) ______________

1) If today's visit is due to an injury at work please check: ❐
2) Have you notified your personnel department? ❐ YES ❐ NO
3) Please give brief description of injury: ______________________________

____

____

POLICY HOLDER (GUARANTOR) EMPLOYER INFORMATION

Policy holder name: ______________________________

Address: ______________________________
Street City State ZIP

Policyholder date of birth: ______________ Social Security #: ______________ Sex: ❐ M ❐ F

Policy holder employer name: ______________________________

Address: ______________________________
Street City State ZIP

INSURANCE INFORMATION

Primary insurance company name: ______________ ID/Member #: ______________

Group name: ______________ Group #: ______________

Effective date: ______________ Expiration date: ______________

Patient's relationship to policyholder: ______________ Policyholder name: ______________

Secondary insurance company name: ______________ ID/Member #: ______________

Group name: ______________ Group #: ______________

Effective date: ______________ Expiration date: ______________

Patient's relationship to policyholder: ______________ Policyholder name: ______________

EMERGENCY CONTACT INFORMATION

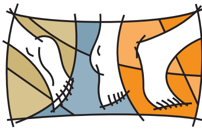
Name: ______________ Address: ______________

Home phone: ( ) ______________ Work phone: ( ) ______________ Ext.:__________

EXPLANATION OF PAYMENT POLICY AND INSURANCE FILING PROCEDURES

I hereby authorize Southwest Podiatry, LLP, to release medical information and necessary data pertinent to the filing of insurance papers in the interest of the patient named above and the facility. I authorize my insurance carriers to pay benefits directly to Southwest Podiatry on any unpaid services filed on my behalf by Southwest Podiatry. I understand that I am responsible for payment to Southwest Podiatry for charges for the above patient, regardless of my insurance coverage. I also understand that Southwest Podiatry is not ultimately responsible for collecting my insurance or negotiating settlements of claims.

Patient's signature: ______________________________ Date: ______________



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Patient History Form

Please fill out the following confidential form for our records.

Patient name: ________________________ Age: ______ Height: _______ Weight: ______ Shoe size: ______

Current foot or ankle problem: ____

____

When did the problem start? ____

What has been done to treat the problem? ____

Are you or have you been under a physician's care in the past two years? Yes ______________ No ______________

If yes, please explain: ____

Name of family physician: ________________________ Date last seen: ______________

Name of former podiatrist: ________________________ Date last seen: ______________

What conditions were you treated for: ____

MEDICAL HISTORY

- ❒ Diabetes
- ❒ Gout
- ❒ Heart disease
- ❒ High blood pressure
- ❒ Stroke or heart attack
- ❒ Stomach ulcer/reflux
- ❒ Thyroid disease
- ❒ Liver disease
- ❒ Kidney or bladder
- ❒ Bleeding disorders (sickle cell)
- ❒ Anemia/blood
- ❒ Asthma/bronchitis
- ❒ Rheumatic fever
- ❒ Accident/injuries
- ❒ Immune disease (HIV, AIDS)
- ❒ Cancer
- ❒ Epilepsy/seizures
- ❒ Depression or anxiety
- ❒ Vascular/circulatory disease
- ❒ Arthritis
- ❒ Foot problems
- ❒ Other______________

____

____

Please explain any positive responses from above information: ________________________________

____

MEDICATIONS (please include dosage of each)

1) ________________________ 5) ________________________

2) ________________________ 6) ________________________

3) ________________________ 7) ________________________

4) ________________________ 8) ________________________

ALLERGIES: (penicillin, novocaine, tape, foods, etc.)

1) ________________________ 3) ________________________

2) ________________________ 4) ________________________

SURGERIES and HOSPITALIZATIONS: (describe procedure, year and any complications)

1) ____

2) ____

3) ____

4) ____

SOCIAL HISTORY

Occupation: ________________________ Tobacco: If yes, how much? ______________

Alcohol: If yes, how much? ______________ Illicit drugs: If yes, how much? ______________

FAMILY HISTORY (diabetes, heart disease, gout, cancer, foot problems or other): ______________

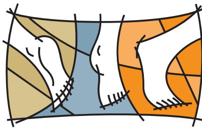
____

____

Whom may we thank for referring you to our office? ________________________________

I hereby give Southwest Podiatry, LLP, permission to diagnose and administer treatment for my foot condition and authorize any release of information obtained in the course of my treatment.

Signature: ________________________________ Date: ______________



Consent for Release of Information/Records

Date: _____/_____/_____

Patient's name: ____

Social Security #: ____________ - __________- ____________

I hereby give my permission for: ____

(name of agency, hospital, doctor, etc…)

Address: ____

Street City State ZIP

To release or disclose to: ____

(name of agency, hospital, doctor, etc…)

Address: ____

Street City State ZIP

Home phone: ( ) ________________________ Work phone: ( ) ________________________ Ext.:_________

The following information, which shall be limited to: ____

For the period between ______________________ through ______________________

I authorize this information to be released in ❒ written form ❒ verbally

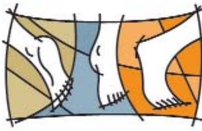
The requested information will be used for: ____

This consent is subject to revocation at any time in the form of written notice from me, except to the extent that action has been taken in reliance thereon, or without revocation, will expire on _____/_____/_____ (this is not to exceed one year.)

Signature of patient: ____ Date: _____/_____/_____

Signature of parent: ____ Date: _____/_____/_____

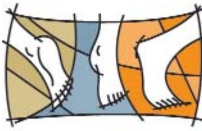
Signature of witness: ____ Date: _____/_____/_____



Disclaimer

Your insurance coverage will be verified. This is quote of your medical benefits. Payment is not guaranteed until the claim is submitted and reviewed. In the event your insurance denies payment, you are responsible for the balance in full. At the time of your visit, you are responsible for the co-payment where applicable and/or percentage and/or deductible (if not satisfied this year), according to information obtained from your insurance company.

Signature Date



Acknowledgement of receipt of notice of privacy practices

I acknowledge that I was provided a copy of the notice of Privacy which is located on the our web site, and that I have read (or had the opportunity to read if I so choose) and understand the notice

Print Name Date

Parent or authorized signature

Patient Signature