DOVER FOOT SPECIALTY CENTER

1 PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____
City State Zip

Email Address_____

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Birthdate _____

Whom may we thank for referring you?_____

_____

2 INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_____

Birthdate _____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dover Foot Specialty Center 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dover Foot Specialty Center for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

3 PHONE NUMBERS

Home _____ Cell_____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Home Phone_____ Work Phone_____

4 PODIATRIC HISTORY

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

_____

_____

On a scale of 1-10, with 10 being the worst, please note your pain level

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Activities you participate in

_____

_____

Is there any family history of diabetes?

☐ Yes ☐ No

If yes, who:_____

Cigarette/Tobacco use?_____

# of packs_____

Years smoked_____

Alcohol

1-2 week____ Greater 1-2 day____

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

Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Callouses	☐ Yes	☐ No
Cramps or Numbness in Feet or Legs	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Heel Pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Plantar's Warts	☐ Yes	☐ No

– OVER –

5 MEDICAL HISTORY

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

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Alzheimers	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fibromyalgia	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Foot or Leg Cramps	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anxiety / Depression	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	R.L.S.	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swelling in Ankles, Feet	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Thyroid	☐ Yes	☐ No
Chronic Diarrhea	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Chronic Fatigue	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Diabetes I	☐ Yes	☐ No	Lyme Disease	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes II	☐ Yes	☐ No	Neuropathy	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Ear Problems	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No			

Surgeries you have had_____

_____

Do you need to take antibiotics prior to dental procedures ☐ Yes ☐ No

Shoe Size?_____ Current Weight _____ Height _____

Hospitalization other than for the surgeries listed_____

Do you have any history of blood clots? _____

Do you have any artificial joints?_____

Do you have a heart valve implant? _____ Heart murmur?_____

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_____

Females: Is there a possibility you are pregnant?_____

6 MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins_____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s)_____

7 ALLERGIES

☐ None	☐ Codeine
☐ Adhesive/Tape	☐ Demerol
☐ Aleve	☐ E-mycin
☐ Lidocaine	☐ Ibuprofen
☐ Anticoagulant Therapy	☐ Iodine
☐ Aspirin	☐ I.V. Dye
☐ Bactrim	☐ Percocet
☐ Ceclor	☐ Vicodin

Other_____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature_____ Date_____