# Southeastern Podiatry Clinic

Print

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## PATIENT INFORMATION

Name_____ Date_____
(First) (Last) (MI)

Address_____ City_____ State_____ Zip_____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ SSN_____ D.O.B._____

Height: _____ Weight: _____ Sex: Marital Status:

Who referred you to our office? _____ Who is your primary physician?_____

Employer_____ Spouse's Name_____

Pharmacy _____ Address _____ Phone _____

***if patient is a minor, parent or guardian, please complete responsible party information***

Parent Name_____ Relationship_____

Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

## EMERGENCY CONTACT

Name_____ Phone _____ Relationship_____

## INSURANCE INFORMATION

Primary Insurance Company_____ Policy # _____

Policy Holder_____ DOB_____

Secondary Insurance Company_____ Policy # _____

Policy Holder_____ DOB_____

**INSURANCE AUTHORIZATION**: I request that payment of authorized benefits be made to the above facility on my behalf, for any services provided to me. I authorize any holder of medical and other information about me can be released to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, or any other information needed to determine benefits for related services. I agree to pay for all charges not covered by my insurance. I authorize a copy of this authorization to be used in place of the original document.

Signed_____ Date_____
(*patient or person authorized to consent for patient*)

Patient: _____

# MEDICAL INFORMATION

## INFORMATION ABOUT CURRENT PROBLEM

Describe your foot/ankle problem _____

_____

How long has it bothered you?_____ Please rate your pain ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10
Mild Severe

What makes your condition worse?_____

What makes your condition better?_____

Have you tried to treat this condition? (soaks, pads, changing shoes, medications) ☐YES ☐NO

If YES, please explain_____

Have you been treated by another doctor for this problem? ☐YES ☐NO If so, who?_____ when?_____

## GENERAL HEALTH INFORMATION

Tobacco use? ☐YES ☐NO Do you drink alcohol or beer? ☐YES ☐NO

***PATIENT MEDICAL HISTORY***

Check all that you HAVE or HAVE HAD a problem with:

| | | | |
|---|---|---|---|
| ☐ Blood Thinners | ☐ Liver Disease | ☐ Pain (feet/leg) | ☐ Diabetes (IDDM) |
| ☐ Heart Disease | ☐ Stomach Ulcers | ☐ Diabetes (NIDDM) | ☐ Cholesterol Problems |
| ☐ Pacemaker | ☐ GERD/Reflux | ☐ Lupus Erythematous | ☐ Thyroid Problems |
| ☐ Hypertension | ☐ Arthritis | ☐ Psoriasis | ☐ Abnormal Bleeding |
| ☐ Bronchitis | ☐ Back Pain | ☐ Skin Cancer | ☐ Anemia |
| ☐ Asthma | ☐ Foot Ulcers | ☐ Burning/Numbness | ☐ Blood Clots |

***CURRENT MEDICATIONS***

_____

_____

_____

***DRUG ALLERGIES***

_____

_____

***FAMILY HISTORY***

Please list any family medical history:

☐ Cancer Relation: _____

☐ Heart Disease Relation: _____

☐ High Blood Pressure Relation: _____

☐ Diabetes Relation: _____

☐ Depression/Mental Disorders Relation: _____

☐ Other _____ Relation: _____