FAYETTE PODIATRY

631 A National Pike, Brownsville, PA 15417
Phone: 724-785-8060 Fax: 724-785-6217

DATE: _____ Marital Status: S – M – W – D Race: _____ Gender: Male - Female

Name:_____ Social Sec #_____-_____-_____
(Last) (First) Middle Initial)

Address:_____ City_____ State:_____ Zip:_____

Home Phone #:_____-_____-_____ Cell Phone #:_____-_____-_____ Work Phone #: ___-____-____

Date of Birth: _____ /_____/_____ Age:_____ Email Address:_____
(month) (day) (year)

***Insurance Plan:_____ ID#_____ Grp#_____*

HEIGHT : _____ WEIGHT:_____ Shoe Size:_____

Employer:_____ _____ Phone_____ Occupation_____

Emergency Contact: _____ Emergency Contact Phone_____

Emergency Contact Address: _____

Pharmacy Name _____ Pharmacy Number_____

Primary Care Physician:_____ PCP Phone#:_____

When did you last see your PCP?_____ Referred By:_____

Please List your CURRENT MEDICATIONS: _____

_____

What is your CURRENT Foot Problem (Please specify which foot, toe, area) _____

_____

Have you ever broken your foot/ankle? ( ) Yes ( ) No Have you previously had foot/ankle surgery? ( )Yes ( ) No

Are you in good general health? ( )Yes ( )No. If No please explain:_____

Please Check (√) if you are allergic to any of the following :
( ) Anesthetics ( ) Food ( ) Latex ( ) Materials ( ) Medications ( ) Novocain ( ) Penicillin's ( ) Tape ( ) Other

Please specifiy:_____

Family Medical History

	Age	Medical Conditions	If deceased, cause of death
Father	____	_____	_____
		_____	
		_____	
Mother	____	_____	_____
		_____	
		_____	

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED WITH A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAVE HAD THE OPPORTUNITY TO READ IF I CHOOSE) AND UNDERSTAND THE NOTICE

_____	_____	_____
PRINT NAME	DATE OF RECEIPT	PARENT OR AUTHORIZED PERSONAL REPRESENTATIVE

_____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform my doctor.

I will authorize my insurance company to pay the doctor or medical group all insurance benefits payable to me for services rendered. I authorize the user of this signature on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits**.**

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date_____

PAYMENT IS DUE AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

SIGNATURE ON FILE: In order to submit a claim for payment to us or for reimbursement to you for services covered under your policy. We must have your authorization to release medical information to your insurance carrier.

I hereby authorize a physician of Fayette Podiatry Associates to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by FAYETTE PODIATRY ASSOCIATES. And direct my insurance carrier or its intermediaries to issue payment checks directly to Fayette Podiatry Associates for services I did not pay for.

I understand that I am financially responsible to Fayette Podiatry Associates for any balances not covered by my insurance carrier.

Signature_____ Date_____

Please complete the following information to the best of your ability.
Do you have any of the following conditions? (Please check or X where appropriate/when answer is yes)

□ Diabetes Type 1 □ Diabetes Type 2 Do you use insulin? □ Yes □No
What was your most recent HbA1c? _____ What was your morning blood sugar _____
Do you have diabetic Eye of Kidney complications? □ No □ Yes Eye □ Yes Kidney

□ Cancer
Type/Region of cancer _____ Active or in Remission _____ Current treatment _____

□ Surgery History
Type and Year:_____
□ Chronic Pain Issues If yes, location: _____
□ Back issues If yes, current treatment: _____

□ Trauma (Car accident, fall, etc.) or Back issues
Describe:_____

□ Stroke □ Kidney Disease □ Liver Disease □Vascular Disease
Are you on dialysis? □ Yes □No

□ Bleeding disorder or Hereditary Disease
Describe: _____
□ New Diagnoses/Conditions since your last appointment
_____
_____

Do you use Tobacco? □Never Smoked □ Current smoker # of yrs____ □ Former smoker # of yrs___
Do you Drink Alcohol? □No □ Yes, # of drinks per week _____ □Former Alcohol Addiction
Do you use recreational drugs? □No □ Yes Type of drug/frequency:_____
Did you get a flu shot? □No □ Yes If Yes, estimated date: _____
What was your most recent height and Weight? Ht:_____ Wt: _____

Check any of the following that you have experienced/ are experiencing.

□ Recent weight changes	□ Fatigue	□ Travel outside of the U.S	□ Visual disturbances
□ Sinus problems	□ Hearing loss	□ Arrhythmias/Heart issues	□ High Blood Pressure
□ Shortness/ issues breathing	□ Coughing/hoarseness	□ Wheezing or asthma	□ Loss of appetite
□ Gastric ulcers	□ Rectal bleeding	□ Confusion	□ Depression
□ Connective tissue disorders	□ Thyroid disease	□ Issues urinating/blood in urine	□ Kidney disease
□ Muscle/joint pain or complaints	□ Bleeding tendency	□ Dizziness or fainting	□ Seizures or frequent
□ Recurring headaches	□ Flu like symptoms	□ Chest pain	□ High Cholesterol

If **YES**, please elaborate below:

_____

_____

Allergies: _____

_____ _____ _____

Printed Name Signature Date