FAYETTE PODIATRY
WELCOME

We are pleased to welcome you to Fayette Podiatry. Please take a few minutes to fill out this form completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Name ______________________________ Soc. Sec. # __________
Last Name First Name Middle

Address ______________________________

City ______________________ State __________ Zip __________

Home Phone # ______________________ Work Phone # ______________________

Cell Phone # ______________________ Sex __________ Marital Status __________

Birthday ______________ Age _____

Patient Employer ______________________ Occupation __________

Employer Address ______________________ Employer Phone __________

Notify in case of emergency ______________________ Phone __________

Whom may we thank for referring you ______________________

Family Physician ______________________ Date of last visit __________

Height ______________ Weight ______________ Shoe Size __________

List of Medications you are currently taking:

____

____

____

____

Are you in good general health? ☐ Y ☐ N If no, explain ______________________________

____

Are your feet tired at the end of the day? ☐ Y ☐ N Do you have lower back pain? ☐ Y ☐ N

Have you ever broken a bone in your foot or ankle? ☐ Y ☐ N Have you had previous foot/ankle surgery? ☐ Y ☐ N

Do you use tobacco products? ☐ Y ☐ N If yes, what amount daily? ______________________

____

Check (✓) if you have had any of the following:

- ☐ Arthritis, Rheumatism
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Cramps/Numbness in feet or legs
- ☐ Diabetes
- ☐ Eye trouble
- ☐ Heart trouble
- ☐ High blood pressure
- ☐ Kidney trouble
- ☐ Liver trouble
- ☐ Swelling of feet or ankles
- ☐ Varicose veins

Are you allergic/sensitive to:

- ☐ Anesthetics
- ☐ Drugs
- ☐ Foods
- ☐ Materials
- ☐ Novocaine
- ☐ Penicillin
- ☐ Tape
- ☐ Other

What is the nature of your foot problem? ______________________________

OVER PLEASE

Primary Insurance

Person Responsible for Account ______________________________
Last Name First Name Initial

Relation to Patient ______________ Birth Date__________ Soc. Sec. # ______________

Address (if different from patient)______________________________ Home Phone ______________

City______________________________ State__________ Zip__________

Cell Phone ______________________________ Email ______________________________

Person Responsible employed by ______________________________ Occupation ______________

Business Address ______________________________

Business Phone ______________________________ Business Email ______________________________

Insurance Company ______________________________

Phone ______________________________ Email ______________________________

Contract #______________ Group #______________ Subscriber #______________

Name of other dependents under this plan ______________________________

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No ______________________________

Subscriber Name______________ Relation to Patient______________ Birth Date______________

Address (if different from patient)______________ City______________ State________ Zip__________

Soc. Sec. #__________ Home Phone__________ Cell Phone__________ Email__________

Subscriber Employed by______________ Business Phone______________ Business Email______________

Insurance Company______________ Phone______________ Email______________

Contract #______________ Group #______________ Subscriber #______________

Name of other dependents under this plan______________________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES...
I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (or had the opportunity to read if I so chose) AND UNDERSTAND THE NOTICE.

______________________________ ______________.
PATIENT'S NAME (please print). Date.

____
PARENT OR AUTHORIZED REPRESENTATIVE (If applicable).

____
SIGNATURE OF PATIENT, PARENT OR AUTHORIZED REPRESENTATIVE

IN CASE OF EMERGENCY OR RELEASE OF INFORMATION PLEASE PROVIDE INFORMATION ON NEXT OF KIN, RELATIVE OR GUARDIAN.

____
NAME (relationship)

____
ADDRESS

____
PHONE

____
DATE OF BIRTH

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 the doctor.

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use 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 in full at time of treatment unless prior arrangements have been approved.