

Patient Information Sheet

Welcome to our Office...

Attention: Please fill out this form COMPLETELY, write N/A where applicable and sign it. Thank you.

Social Security#				
First Name:		Last Name:		Middle Initial:
Date of Birth: (MM/DD/YYYY) ____/____/____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Address:		Apt.#: _____	City: _____	State: _____ Zip: _____
Home Phone: (____) _____		Work Phone: (____) _____	Cell Phone: (____) _____	
Emergency Contact:		Emergency Telephone#: (____) _____		
Employer Name:		Occupation:		

Ref Dr:	Ref Dr's Add / City / State / Zip	Ref Dr NPI #
Primary Care Physician:	PCP Add / City / State / Zip	PCP NPI #

<u>Primary Insurance Company Information:</u>	<u>Secondary Insurance Company Information:</u>
Policy Holder First Name:	Policy First Name:
Policy Holder Last Name:	Policy Holder Last Name:
Policy Holders SS# Policy Holders Date of Birth:	Policy Holders SS# Policy Holders Date of Birth:
Gender: Relationship to Policy Holder:	Gender: Relationship to Policy Holder:
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Policy Holder's Address: <input type="checkbox"/> Same as patient	Policy Holder's Address: <input type="checkbox"/> Same as patient
City: State: Zip:	City: State: Zip:
Insurance Name:	Insurance Name:
Policy ID: Group #:	Policy ID: Group #:
Claim Submission Address:	Claim Submission Address:
Effective Date: ____/____/____	Effective Date: ____/____/____
Do you have a Co-pay? <input type="checkbox"/> No <input type="checkbox"/> Yes, Amt \$ _____	Do you have a Co-pay? <input type="checkbox"/> No <input type="checkbox"/> Yes, Amt \$ _____
Referral Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	Referral Required: <input type="checkbox"/> Yes <input type="checkbox"/> No

Responsible Party Information – Please complete if the responsible for payment is not the <u>Patient</u> or the <u>Policy Holder</u> .		
Responsible Party's Name (Last / First):	Responsible Party's SSN:	Relationship to Responsible Party:
_____	_____ - _____ - _____	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Responsible Party's Address / City / State / Zip:		

FINANCIAL POLICY

I hereby authorize the release of any medical information necessary to process this claim and hereby assign to the physician all payments for medical services rendered to my dependents or myself. I understand that it is as a courtesy that the doctor accepts my insurance for payment and that if for any reason they do not pay my bill that I am responsible.

The Practice accepts personal checks. In the event that a check 'bounces' (i.e., insufficient funds exist to cover the check), a fee of \$25 will be applied.

All patients receive a reminder call for upcoming appointments. Failure to appear or call to cancel prior to an appointment (no show) will result in a \$25 fee.

By signing below, I acknowledge and agree to abide by this policy. I also acknowledge that I have been given the opportunity to review the Health Insurance Portability and Accountability Act (HIPPA) Notice of Privacy Practices and I agree to comply with all of its terms.

Today's Date: _____ Patient's Signature (or parents if under 18 years of age): _____

Beaumont Foot Specialists

NAME _____ DATE OF BIRTH _____ DATE _____

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PODIATRIC HISTORY

CHIEF COMPLAINT (reason for your visit here today) _____

DESCRIBE TYPE OF PAIN:
Dull Aching Sharp
Shooting Throbbing Burning
Tingling Cramping Numbness
Other _____

LOCATION: Right Left Both
Foot Ankle Leg Knee

DURATION (How long have your symptoms been present): _____ Days Weeks Months Years

ONSET: Slow Sudden Traumatic

IF TRAUMATIC: Auto Worker's Comp Other

HAS PAIN BECOME: Better Worse Stayed the same

SYMPTOMS ARE WORSE: Morning Evening Night All Day

Scale Level: 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

WHAT AGGRAVATES THE CONDITION? LIST PREVIOUS TREATMENTS: _____

PREVIOUS PODIATRIST?

WHO IS YOUR PRIMARY PHYSICIAN? _____

WHO? _____
WHEN? _____
doctor

May we contact your physician regarding your care? Y
Date you last saw your primary

MEDICAL HISTORY

Please circle Yes or No to indicate if you have had any of the following:

Table with 3 columns of medical conditions and Yes/No response options. Includes conditions like AIDS/HIV, Anemia, Anxiety, Arthritis, Depression, Diabetes, Liver Disease, etc.

WOMEN, are you.....Pregnant? Y N Breastfeeding? Y N

NAME _____

DATE OF BIRTH _____

DATE _____

MEDICATIONS

Please include prescriptions, over-the-counter medications, and vitamins. (Or provide a list to be photocopied):

Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____

ALLERGIES

Any allergies or adverse reactions to the following? (please list type of reaction)

Local anesthesia _____	Y N	General anesthesia _____	Y N
Aspirin _____	Y N	Latex _____	Y N
Anti-inflammatory _____	Y N	Tape/Adhesives _____	Y N
Penicillin _____	Y N	Iodine _____	Y N
Sulfa _____	Y N	Betadine _____	Y N
IVP dye _____	Y N	Codeine _____	Y N
Tetanus _____	Y N	Steroids _____	Y N
Other antibiotics (name) _____			
Other medications (name) _____			

Preferred Pharmacy: _____

Pharmacy phone #: _____

SURGICAL AND HOSPITALIZATION HISTORY

Please list previous surgeries and hospitalizations with approximate dates (year):

SOCIAL HISTORY

Your Occupation: _____

Do you smoke? _____	Y N	How many packs/day? _____
Did you smoke previously? _____	Y N	Packs/day? _____ How many years? _____
Do you drink alcohol? _____	Y N	If so, how much? _____ How often? _____

Age: _____ Height: _____ Weight: _____ Shoe Size: _____

Beaumont Foot Specialists

NAME _____

DATE OF BIRTH _____

DATE _____

FAMILY HISTORY

Family history (mother, father, grandparents, or siblings) of: WHO?

Heart Disease.....	Y	N	_____
Diabetes.....	Y	N	_____
High Blood Pressure.....	Y	N	_____
Stroke.....	Y	N	_____
Varicose Veins.....	Y	N	_____
Gout.....	Y	N	_____
Arthritis.....	Y	N	_____
Neuropathy.....	Y	N	_____
Bleeding Disorder.....	Y	N	_____
Foot Problems.....	Y	N	_____

Mother: Living _____ Age _____
 Deceased _____ Age _____ Cause _____

Father: Living _____ Age _____
 Deceased _____ Age _____ Cause _____

Brother(s): Living _____ Age(s) _____
 Deceased _____ Age(s) _____ Cause _____

Sister(s): Living _____ Age(s) _____
 Deceased _____ Age(s) _____ Cause _____

REVIEW OF SYSTEMS (Circle any problems you are currently having)

- CONSTITUTIONAL..... fever, weight loss, weakness, fatigue
- SKIN..... dry skin, excessive sweating, itching, sores, rashes, color change
- HEMATOLOGICAL..... swollen glands, easy bruising, previous blood transfusion
- HEENT..... headaches, sinus problems, allergies, nosebleeds, visual or hearing problems, wear contacts or glasses, gum disease, problems with teeth, sleep apnea, snoring
- CHEST/RESPIRATORY..... cough, shortness of breath, wheezing, bronchitis, pneumonia,
- CARDIOVASCULAR..... heart trouble, chest pain/angina, swelling of legs/feet, irregular Heartbeat
- ABDOMINAL..... Liver disease, hepatitis, jaundice, gallbladder problems, irritable bowel syndrome, colitis, polyps, diverticulitis, heartburn, peptic ulcer, diarrhea, constipation, dark stools
- GENITOURINARY..... kidney stones, kidney disease, bladder dysfunction, pain with urination, blood in urine, ovarian cysts, uterine fibroids, hernia
- ENDOCRINE..... thyroid problems, hormonal changes, diabetes, excessive thirst, recent weight loss or gain, heat or cold intolerance
- MUSCULOSKELETAL..... neck or low back pain, arthritis, joint pain, muscle pain, stiffness, hip, shoulder or knee problems, carpal tunnel
- NEUROLOGICAL..... seizures, fainting spells, blackouts, weakness, dizziness, tremors, gait problems, memory problems, neuropathy, concentration difficulty, depression, anxiety