Academy of Podiatry

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PATIENT INFORMATION

(CONFIDENTIAL INFORMATION)

PLEASE PRINT CLEARLY

DATE: _____

_____

Patient's Last Name First Name MI Age Sex

By What Name Do You Wish To Be Called? _____

Birthdate_____ Single_____ Married_____ Widowed_____ Divorced/Sep. _____

Email Address:_____

Social Security No. _____ Preferred Phone Number_____

Home Address _____ Apt. No._____

City_____ State_____ Zip Code _____

(Please Check): Employed _____ Full Time Student _____ Part Time Student _____

Patient's Occupation_____

Employer/School Name_____

Employer/School Address_____

Employer/School Phone No. _____ (Please Include Area Code)

Spouse's Name _____ Spouse's Birth Date: _____

Spouse's Employer/School_____

Spouse's Employer/School Address_____

Spouse's Employer/School Phone No. _____

If Patient is a Minor: Father's Birthdate _____ Mother's Birthdate _____

Whom May We Thank for Referring You to Us? _____

Address, if known _____

MEDICAL HISTORY

Family Physician (doctor name not group)_____
Family Physician Phone No._____
Date of Last Physicial/Visit_____
Please Describe Your Current Foot Problem_____

Please Check Any Of The Following For Which You Have Been Or Are Being Treated.

- ☐ Diabetes
  (Last Sugar Reading_____)
  (Diabetic doctor_____
  _____
- ☐ Hypertension
  (High Blood Pressure)
- ☐ Cerebral Accident (Stroke)
- ☐ Cardiac Disease
- ☐ Peripheral Vascular Disease
  (Poor Circulation)
- ☐ Phlebitis/Thrombo
- ☐ Scarlet Fever
- ☐ Rheumatic Fever
- ☐ High Cholesterol
- ☐ Anemia
- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ Gout
- ☐ Glaucoma/Eye
- ☐ Thyroid (Hypo or Hyper)
- ☐ Epilepsy
- ☐ Polio
- ☐ Cerebral Palsy
- ☐ Muscular Dystrophy
- ☐ Neurological Disease
- ☐ Gastrointestinal Disorders
- ☐ Cancer
- ☐ Renal Disease
- ☐ Hepatitis (Liver Disease)
- ☐ Venereal Disease
- ☐ AIDS or HIV
- ☐ Hemophilia (Bleeder)
- ☐ OTHER (Please State):
  _____
  _____
  _____
  _____
  _____

Women: Are You Pregnant? _____ Due Date_____

Family History

Please list any significant health conditions for blood related relatives:
Mother:_____ Father:_____
Siblings:_____ Offspring:_____

Allergies

Please Check Any Known Allergies

_____ Penicillin _____ Tetracycline _____ Barbiturates _____ Cortisone
_____ Novocain _____ Codeine _____ Adhesives/Tape _____ Caffeine
_____ Iodine _____ Aspirin _____ Sulfa
_____ Foods (Please Specify): _____
_____ Other (Please Specify): _____

Medications

Are You Taking Any Medications Currently? Yes_____ No_____
If Yes, Please List (Include Vitamins or Birth Control Pills). Please Include Dose, Frequency and Route of Administration:

Med Name	Dose	Freq.	Route	Med Name	Dose	Freq.	Route

Previous Surgeries

Have You Had Any Previous Surgery or Hospitalization? (Include Fractures/Dislocations)

Yes _____ No _____ If Yes, Please List:_____

_____

_____

PLEASE CHECK ANY THAT APPLY

SOCIAL HISTORY:

Alcohol _____ Recreational Drugs _____ Caffeine _____

Smoker/Nicotine: _____No _____Former _____Yes:_____ per day

REVIEW OF SYSTEMS:

HEAD, EYE, EAR, NOSE, THROAT:

_____Headaches _____Trauma _____Glasses _____Cataracts _____Glaucoma

_____Hearing Loss _____Polyps _____Vertigo _____Obstruction _____Drainage

_____Discharge _____Dentures _____Difficulty Swallowing _____Hoarseness

RESPIRATORY:

_____Cough _____Lung Disease _____Shortness of Breath

CARDIO:

_____Heart Attack _____Angina _____Abnormal EKG _____High Blood Pressure

GASTROINTESTINAL:

_____Ulcers (Stomach/Intestinal) _____Hiatal Hernia _____Esophageal

GENITOURINARY:

_____Kidney/Bladder _____Hematuria _____Infections

GYNECOLOGICAL:

_____Hysterectomy _____Cysts _____Tubal Ligation

NEUROLOGICAL:

_____Hereditary _____CNS _____Psychological _____Autonomic

MUSCULOSKELETAL:

_____Arthritis _____Muscles _____Tendons

HEMATOLOGICAL:

_____Clots _____Anemia _____Transfusions _____Phlebitis _____Stroke

THE FOLLOWING IS REQUIRED BY LAW, PLEASE SIGN AND DATE IT

I hereby authorize Academy of Podiatry to release any information to the Health care Financing Administration, Pennsylvania Medical Assistance, and/or my insurance company as required in the course of any exam and or treatment by Academy of Podiatry.

I authorize any holder of Medicare information relating to my treatment to release to any Carrier that may be named as my Medigap insurer any and all information needed to determine benefits payable for related services.

I understand that my signature certifies that I have requested and received services/procedures/items by Academy of Podiatry.

I understand that payment for these services/procedures/items may be Federal and or State Funds and that any false claims, statements, documents, or concealment of material may be prosecuted under applicable Federal and or State Laws.

I hereby request that payment be made directly to Academy of Podiatry of any authorizing Medicare, Pennsylvania Medical Assistance and or other insurance company for any and all services rendered to me through Academy of Podiatry.

I agree and understand that all services rendered to me by Academy of Podiatry were necessary for treatment of my condition(s) and that I am personally responsible for all charges which Medicare, Pennsylvania Medical Assistance and any other insurance company may not pay, including, but not limited to co-insurances, deductibles and any non-covered services.

I agree to make payment in full for all services due by me personally within 25 days of receipt of billing.

I understand and agree that this authorization will remain in effect until such time that I request in writing, termination of this authorization.

Signature _____ Date:_____

ACADEMY OF PODIATRY

ACKNOWLEDGEMENT FORM

PRIVACY PRACTICES ACKNOWLEDGEMENT

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosure of their protected information, (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of individual's homes.

I wish to be contacted in the following manner (check all that apply)

Home Telephone _____

- ☐ Ok to leave message with detailed information.
- ☐ Leave message with call back number only

Work Telephone_____

- ☐ Ok to leave message with detailed information.
- ☐ Leave message with call back number only.

Cellular Phone _____

- ☐ Ok to leave message with detailed information.
- ☐ Leave message with call back number only.

Written communication:

- ☐ Ok the mail to my home address
- ☐ Ok to mail to my work /office

You may release my health information to:

Name: _____

Number: _____

Relationship: _____

Name:_____

Number: _____

Relationship: _____

I have received the notice of Privacy Practices and I have been provided an opportunity to review it

Printed Name_____ Signature_____

Date:_____