Kutchback Podiatry, PA

Patient Information Sheet

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

Welcome to our Office…

Social Security#

First Name: **Last Name:** **Middle Initial:**

Date of Birth: (MM/DD/YYYY) **Age:** **Gender:** ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Other

_____ / _____ / _____ _____

E-Mail Address:

Address: **Apt.#:** **City:** **State:** **Zip:**

Home Phone: (_____) _____ **Work Phone:** (_____) _____ **Cell Phone:** (_____) _____

Emergency Contact: **Emergency Telephone#:** (_____) _____

Employer Name: **Employer's Address / City / State / Zip**

Referred by: **Referred Person's Address / City / State / Zip** **Referring Person's Phone#** (_____)_____-_____

Primary Care Physician: **Primary Care Physician's Address / City / State / Zip** **P.C.P.'s Phone#** (_____)_____-_____

PRIMARY Insurance Company Information:	**SECONDARY** Insurance Company Information:
Policy Holder First Name & Last Name:	**Policy First Name & Last Name:**
Policy Holders SS# _____-_____-_____ **Policy Holders Date of Birth:** _____ / _____ / _____	**Policy Holders SS#** _____-_____-_____ **Policy Holders Date of Birth:** _____ / _____ / _____
Gender: ☐ Male ☐ Female **Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other	**Gender:** ☐ Male ☐ Female **Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other
Policy Holder's Address: ☐ **Same as patient**	**Policy Holder's Address:** ☐ **Same as patient**
City: **State:** **Zip:**	**City:** **State:** **Zip:**
Insurance's Name:	**Insurance's Name:**
Policy ID: **Group #:**	**Policy ID:** **Group #:**
Claim Submission Address:	**Claim Submission Address:**
Effective Date: _____ / _____ / _____	**Effective Date:** _____ / _____ / _____
Do you have a Co-pay? ☐ No ☐ Yes, Amt $_____	**Do you have a Co-pay?** ☐ No ☐ Yes, Amt $_____
Referral Required: ☐ **Yes** ☐ **No**	**Referral Required:** ☐ **Yes** ☐ **No**

Responsible Party Information – *Please complete if the responsible for payment is not the Patient or the Policy Holder.*

Responsible Party's Name (Last / First): **Responsible Party's SSN:** _____-_____-_____ **Relationship to Responsible Party:** ☐Self ☐Spouse ☐Child ☐Other

Responsible Party's Address / City / State / Zip:

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.

☐ **I have received the Confidentially Agreement (HIPAA) and agree to comply with all its terms.**

Today's Date:_____ Patient's Signature: _____

Kutchback Podiatry, PA

PODIATRY HISTORY

What is the chief concern for which you came to be treated?

_____

_____

When did you notice the problem?_____

Any Other Concerns? _____

_____

Have you ever been to a Podiatrist before? ☐Yes ☐No

If yes, please list:

Name _____Last Visit _____

Is there any personal or family history of diabetes? ☐Yes ☐No

Your occupation _____

Activities in which you participate (frequency):

_____

_____

Please indicate which foot problem you now have or have

Ankle Pain ……....	☐Yes ☐No
Arthritis ……..	☐Yes ☐No
Athlete's Foot ……	☐Yes ☐No
Corns and Calluses ……	☐Yes ☐No
Cramps or Numbness in Feet or Legs …	☐Yes ☐No
Arch Problems..……..	☐Yes ☐No
Foot or Leg Cramps ……..	☐Yes ☐No
Gout ……...	☐Yes ☐No
Heel Pain ……	☐Yes ☐No
Ingrown Toenails ……...	☐Yes ☐No
Plantar Warts …….	☐Yes ☐No
Swelling in Ankles or Feet ……	☐Yes ☐No
Tired Feet ……...	☐Yes ☐No

What makes it better? _____

_____

What makes it worse? _____

_____

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐Yes ☐No	Circulatory Problems	☐Yes ☐No	Phlebitis	☐Yes ☐No
Allergies to Anesthetics	☐Yes ☐No	Diabetes	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Allergies to Medicine or Drugs	☐Yes ☐No	Ear Problem	☐Yes ☐No	Radiation Treatment	☐Yes ☐No
Allergies to Latex	☐Yes ☐No	Epilepsy	☐Yes ☐No	Rash	☐Yes ☐No
Allergies to Penicillin	☐Yes ☐No	Eye Problem	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Anemia	☐Yes ☐No	Fainting	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Angina	☐Yes ☐No	Foot or Leg Cramps	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Arthritis	☐Yes ☐No	Gout	☐Yes ☐No	Sinus Problem	☐Yes ☐No
Artificial Heart Valves or Joints	☐Yes ☐No	Headaches	☐Yes ☐No	Special Diet	☐Yes ☐No
Asthma	☐Yes ☐No	Heart Disease	☐Yes ☐No	Stroke	☐Yes ☐No
Back Problems	☐Yes ☐No	Hemophilia	☐Yes ☐No	Swelling in Ankle, Feet	☐Yes ☐No
Bleeding Disorders	☐Yes ☐No	Hepatitis or Jaundice	☐Yes ☐No	Swollen Neck Glands	☐Yes ☐No
Cancer	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Tired Feet	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Chest Pain	☐Yes ☐No	Liver Disease	☐Yes ☐No	Ulcers	☐Yes ☐No
Chronic Diarrhea	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Varicose Veins	☐Yes ☐No
Cigarette/Tobacco Use	☐Yes ☐No	Neuropathy	☐Yes ☐No	Venereal Disease	☐Yes ☐No

Surgeries/Hospitalization you have had _____

_____

_____

Family Physician _____ Last Visit Date _____

Are you now, or have been, under any other doctor's care for any reason over the past two years? ☐Yes ☐No

If yes, please explain _____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins: _____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

ALLERGIES

☐ Adhesive/Tape	☐ Local Anesthetics
☐ Anticoagulant Therapy	☐ Novocaine
☐ Aspirin	☐ Seafoods
☐ Demerol	☐ Sulfa
☐ Iodine	
☐ Other: _____	

Payments: Patients are responsible for all fees including missed visits and returned checks. Interest and late fees may apply on past due balances. Payment is expected at the time services are rendered. Payments exceptions must be arranged before treatment.

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to provide podiatric services, and medicines, submit my insurance form, consider my signature "on file" for payment, and to release any & all records needed. I understand the privacy policy, and have read and understand the above and agree to be personally responsible for all charges & fees.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date