

Patient Background

Name _____ Birthdate ____ / ____ / ____ Age _____

Address _____
 Number & Street _____ City _____ State _____ Zip code _____

Home phone _____ Cell phone _____ Work phone _____

UW Medical record number (if you have one) _____ Social Security # ____ - ____ - ____

Preferred Language _____ Race _____ Ethnicity _____ Decline to answer

Student Employed by _____ Email _____
(For office use only. We will not provide your email address to any other person or institution for any reason)

In emergency please call _____ Relationship _____ Tel. _____

I was referred to this office by: Physician/nurse _____ Friend _____
 Yellow Pages Internet Insurance Co.

Primary physician: Name, address, tel. # _____

Are you now under the care of a doctor? Yes No. For what condition(s)? _____

Current medications (include dosage) _____

Which pharmacy do you use most often? _____

Please check the box next to any condition you have had:

- | | | | |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hives | <input type="checkbox"/> Gout | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Skin disorder | <input type="checkbox"/> Bleeding tendencies | _____ |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Tumors (benign) | <input type="checkbox"/> Difficulty healing when cut | _____ |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hepatitis | _____ |
- Of what?

Are you allergic or have you had an adverse reaction to any of the following? If yes, please indicate the reaction e.g. rash, itching, difficulty breathing or GI upset.

- | | | | |
|---|--|------------------------------------|--------------------------------------|
| <input type="checkbox"/> No drug allergies | <input type="checkbox"/> Latex | <input type="checkbox"/> Cortisone | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Adhesive tape | <input type="checkbox"/> Demerol | |
| <input type="checkbox"/> Other antibiotic _____ | <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa | _____ |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine | | |
| <input type="checkbox"/> Local anesthetic | | | |

Please describe your current foot problem (why are you here today?): _____

Have you regularly smoked? Yes No

If yes Cigarettes Pipe Cigars For how many years? _____ Number per day _____ Quit date _____

List any previous surgical procedures _____

Have you had previous care by a Podiatrist? Yes No. If yes, for what and when was your last visit? _____

	Yes	No
Do you often have sensations of numbness or tingling in your feet?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience foot or leg cramps when walking?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever broken any bones in your feet or ankles?	<input type="checkbox"/>	<input type="checkbox"/> If yes, which bones and when? _____

Have you had any foot infection in the past two years?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had foot surgery?	<input type="checkbox"/>	<input type="checkbox"/> If yes, what was done? _____

What is your shoe size? _____ Narrow/Medium/Wide and is it Mens/Womens? (Please circle)

Financial Information

Other than insurance, who is responsible for the bill? I am Parent Other _____

Name & address of responsible party if other than yourself: _____ Telephone: _____

Primary Insurance _____ Subscriber # _____ Group # _____

Address _____ Phone Number: _____

Secondary Insurance _____ Subscriber # _____ Group # _____

Insured's (Policy Holder's) name _____ / _____ / _____ Relationship _____
Policy holder's birth date

As a courtesy we will file your insurance claim for you. Your insurance may cover some or all of the costs of your treatment. Please remember that although we will assist you with your claim, you are financially responsible for charges not fully covered by your insurance. If your insurance carrier does not respond to your claim within 45 days, you will be requested to make payments for the services you have received.

If you have any questions regarding the cost of your care, please ask.

HMO & PPO members: If your insurance requires a written, approved referral it is your responsibility to obtain that referral. If you do not have a valid referral at the time of your visit, you will be held financially responsible for the full costs of your treatment.

I understand that my signature requests that insurance payment be made directly to the treating physician. I also authorize the release of medical information necessary to pay the claim.

I have read and understood the above.

Signature _____