MICHAEL G. MEYERS, D.P.M.
PATIENT INFORMATION

FULL NAME:_____ DATE:_____
(First) (Middle) (Last)

ADDRESS:_____ CITY:_____ZIP:_____

HOME PHONE:_____ CELL PHONE:_____ EMAIL:_____

BIRTH DATE:_____ AGE:_____ SEX: M F MARITAL STATUS: S M W D SEP

SOC. SEC. #:_____ REFERRED BY:_____

NAME OF EMPLOYER:_____ WORK PHONE:_____

PHARMACY:_____

SHOE SIZE:_____ WIDTH:_____ WEIGHT:_____lbs. HEIGHT:_____

INSURANCE CARD HOLDER
(IF OTHER THAN PATIENT)

NAME:_____ RELATIONSHIP TO PATIENT:_____

ADDRESS:_____

SOCIAL SEC. #:_____BIRTH DATE:_____ HOME PHONE: _____

EMPLOYER: _____

INSURANCE, MEDICARE, MEDICAID, OR WORKER'S COMPENSATION

COMPANY OR PROGRAM GROUP NUMBER POLICY NUMBER

1. _____

2. _____

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME:_____ HOME PHONE:_____ WORK PHONE:_____

MEDICAL INFORMATION

Describe your FOOT and/or ANKLE PROBLEM(S):_____

_____

_____

How long have you had the problem(s)? _____ Days _____ Weeks _____ Months _____ Years
List any PREVIOUS foot and/or ankle problems you have had:_____

_____

List any previous SURGICAL procedures you have had on your FOOT and/or ANKLE: _____
List any OTHER SURGERIES you have had:_____
Have you had a JOINT replacement, such as a hip or knee joint? ☐ Yes ☐ No – If YES, name - _____
Have you had a HEART VALVE replacement? ☐ Yes ☐ No Do you have any VASCULAR GRAFTS? ☐ Yes ☐ No
Have you had any problems with ANESTHESIA? ☐ Yes ☐ No
List any medication you are ALLERGIC or SENSITIVE to:_____

_____

Have you had any problems taking ASPIRIN or IBUPROFEN (i.e. Advil, Motrin)? ☐ Yes ☐ No

List the MEDICATIONS you are currently taking on a regular basis:_____

_____

_____

Do you have DIABETES? ☐ Yes ☐ No – If YES, number of years _____ Do you take insulin? ☐ Yes ☐ No
List any serious illness(es) you have had:_____

_____

(WOMAN) Are you pregnant? ☐ Yes ☐ No

PRIMARY PHYSICIAN:_____Date Last Seen:_____

Check any of the following conditions you have been treated for or have been informed by a physician that you have:

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Back Problems
☐ Bleeding Disorder
☐ Blood Clots
☐ Bronchitis/Emphysema
☐ Cancer
☐ Circulatory Disorder
☐ Depression
☐ Drug Abuse
☐ Epilepsy / Seizures
☐ Frequent Infections
☐ Gout
☐ Headaches
☐ Heart Problems
☐ High Blood Pressure
☐ High Cholesterol
☐ History of MRSA
☐ HIV
☐ Kidney Problems
☐ Leg Cramps
☐ Liver Problems or Hepatitis
☐ Neurological Disorder
☐ Reflux / GERD
☐ Rheumatic Fever
☐ Sciatica
☐ Stomach Ulcers
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Other _____

Check any of the following symptoms you have recently experienced:

Neuro:	Heme/Lymph:	Metabolic/Endo:	Skin:	MS:
☐ Numbness	☐ Bleed Easily	☐ Hair Changes	☐ Itching	☐ Back Pain
☐ Weakness	☐ Bruise Easily	☐ Always Thirsty	☐ Mole Changes	☐ Joint Pain
☐ Headache	☐ Swelling/Lymph Nodes	☐ Always Hungry	☐ Rash	☐ Joint Swelling
☐ Memory Loss	☐ Neck Pain			☐ Neck Pain

GI:	Constitutional:	Cardio:	GU:	Mood:
☐ Abdominal Pain	☐ Chills	☐ Chest Pain	☐ Burning	☐ Anxiety
☐ Blood in Stools	☐ Tired	☐ Calf Pain With Walking	☐ Urinary Frequency	☐ Depression
☐ Constipation	☐ Fever	☐ Swelling	☐ Rash	☐ Sleeping Problem
☐ Diarrhea	☐ Night Sweats	☐ Palpitations	☐ Incomplete Emptying of Bladder	☐ Suicidal Thoughts
☐ Heartburn	☐ Weight Gain			
☐ Loss of Appetite	☐ Weight Loss			
☐ Nausea				
☐ Vomiting				

Please list any other concerns: _____
_____
_____

Do you smoke? ☐ Yes ☐ No – If YES, number of packs per day: _____
If you PREVIOUSLY smoked, please indicate number of years you smoked: _____
If you drink alcohol or beer, please indicate frequency:
☐ Light Usage (1-2 per week) ☐ Moderate Usage (1-2 per day) ☐ Heavy Usage (2+ per day)

EMPLOYMENT: ☐ Sit at job ☐ Stand at job ☐ Stand and walk at job ☐ Homemaker ☐ Retired

FAMILY HISTORY

Mother: ☐ Living ☐ Deceased - Cause of Death: _____
Father: ☐ Living ☐ Deceased - Cause of Death: _____
Number of Brothers and Sisters: _____ Cause of Death if Deceased: _____

Check any of the following conditions that a FAMILY MEMBER (blood relative) has a history of, and if any apply, please indicate the relationship of that person to you:

☐ Arthritis
☐ Bleeding Disorder
☐ Bunions
☐ Circulation Problems in Legs or Feet
☐ Diabetes
☐ Flat Feet
☐ Hammertoes
☐ Heart Disease
☐ Neurological Disorder
☐ Stroke
☐ Other: _____
_____

AUTHORIZATIONS

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION:
I hereby authorize Michael G. Meyers, D.P.M. (hereinafter referred to as "Provider") to release any information acquired in the course of my treatment to my insurance company deemed necessary for consideration of payment and authorize payment to be made directly to Provider.

PATIENTS WITH HMO COVERAGE:
I understand that if I have not obtained the proper authorization and referral for each and every visit to this office that I am responsible for payment of the services rendered for the date(s) of services not authorized. I understand that it is my responsibility to obtain proper authorization prior to each visit. I understand that I am responsible for any copayment due at the time of each visit.

PATIENTS WITH PPO OR PPOM COVERAGE:
I understand that I am responsible for any copayment due at the time of service.

MEDICARE AUTHORIZATION:
I hereby authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I agree to permit copies of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment.

RELEASE OF MEDICAL INFORMATION:
I hereby authorize the Provider to release medical information to my referring or family physician listed on this form.

Date: _____ Signature: _____