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PATIENT INFORMATION

FULL NAME: ______________________________ DATE: ______________
(First) (Middle) (Last)

ADDRESS: ______________________________ CITY: ____________ ZIP: ________

HOME PHONE: ______________ WORK PHONE: ______________ SOCIAL SEC. NO. ______________

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

REFERRED BY: ______________________________

NAME OF EMPLOYER: ______________________________ WORK PHONE: ______________

SHOE SIZE: ____________ WIDTH:__________ WEIGHT: __________lbs.

INSURANCE CARD HOLDER

(IF OTHER THAN PATIENT)

NAME: ______________________________ RELATIONSHIP TO PATIENT: ______________

ADDRESS: ______________________________

SOCIAL SEC. NO. ______________ 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 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: ______________

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 or ANTIBIOTICS? ☐ Yes ☐ No

List any ANTIBIOTICS or other MEDICATIONS (i.e. penicillin, sulfa, codeine, etc.) 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

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

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

PRIMARY PHYSICAIN: ____

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

Father: ☐ Living ☐ Deceased - Cause of Death: ____

Mother: ☐ 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	☐ Diabetes	☐ Ingrown Toenails
☐ Bleeding Disorder	☐ Flat Feet	☐ Neurological Disorder
☐ Bunions	☐ Hammertoes	☐ Stroke
☐ Circulatory Problems in Legs or Feet	☐ Heart Disease	☐ Other ________________________

AUTHORIZATIONS

ASSIGNMENT OF BENEFIT AND RELEASE OF INFORMATION:

I hereby authorize Michael G. Meyers, D.P.M. / Alpine Family Podiatry, P.C. (hereafter 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 ot 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: ____