

THE PODIATRY GROUP
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WELCOME TO OUR OFFICE

Today's Date: _____ Chart Number: _____

Full Name: _____ Name You Wish To Be Called: _____

Address: _____ City/State/Zip: _____

Social Security Number: _____ Age: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Sex: Male _____ Female _____ Spouse's Name: _____ Spouse's Birthdate: _____

Spouse's SSN: _____ Marital Status: Single _____ Married _____ Widowed _____ Divorced _____

If a child, name of responsible party (please print): _____

Employed by: _____ Occupation: _____ Phone: _____

Family Physician: _____ Phone: _____

Referred By: _____ Last Visit: _____

Do you smoke? _____ Yes _____ No If so, how long? _____

List Any Previous Surgeries: _____

List Any Medication Allergies: _____

List Any Medications You Are Presently Taking: _____

Are You Pregnant or Breastfeeding? _____

State, In Your Own Words, Your Reason For Coming To Our Office: _____

Date of Injury/Accident: _____ Work Related: _____ Yes _____ No

Have You Ever Had (Circle YES or NO)

Diabetes.....Yes No	Heart Problems.....Yes No	Rheumatic Fever.....Yes No	Gout.....Yes No
Stroke.....Yes No	Leg Cramps.....Yes No	High Blood Pressure.....Yes No	Cancer.....Yes No
Epilepsy.....Yes No	Liver Problems.....Yes No	Bleeding Tendencies.....Yes No	Asthma.....Yes No
Glaucoma.....Yes No	Tuberculosis.....Yes No	Peripheral Neuropathy.....Yes No	Hepatitis....Yes No
Anemia.....Yes No	Stomach Ulcers.....Yes No	Peripheral Vascular Disease.....Yes No	Phlebitis.....Yes No
Arthritis.....Yes No	Varicose Veins.....Yes No	Venereal Disease.....Yes No	HIV.....Yes No

Other Medical Conditions Not Listed Above: _____

Primary Insurance Company: _____ Policy No.: _____

Insured's Name: _____ Insurance Phone No.: _____

Secondary Insurance Company: _____ Policy No.: _____

Insured's Name: _____ Insurance Phone No.: _____

Referral Required? _____ Yes _____ No Referral Obtained From Referring Physician? _____ Yes _____ No

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION: I hereby give The Podiatry Group permission to treat my feet and/or ankles. I request that payment of authorized Medicare and/or other insurance company benefits be made to The Podiatry Group for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, and any other insurance company involved, any information needed to determine these benefits payable for related services. I understand that I am responsible for any unpaid portions.

 Signature of Patient or Legal Guardian

Date: _____