Welcome to Shenandoah Podiatry

Date ________________

Name: First ____________________________ M.I. _____ Last __________________________

Sex ____ Date of Birth _______________ S.S.# or Driver's Lic. # _________________________

Address ____

City _______________State ____ Zip Code __________Home Phone ______________________

E-mail ______________________________________Cell Phone ________________________

Employer ______________________________________ Work Phone ___________________

How did you hear about us?

Physician / Friend /Insurance Company/Sign/Internet/ Phone Book /Other*:* _________________

- -

Emergency Contact Information

Name ________________________________ Relationship _________________________

Address ____

Home Phone __________________________ Work Phone _________________________

- -

All Patients Please Read and Sign Below:

WE WILL file your insurance claim for you due to the complexities involved. Although this service is provided free of charge, it does not relieve you of any financial responsibility.

By signing this you:

- Authorize Shenandoah Podiatry to furnish medical photographic, or other information to insurance carriers as well as any other physician we may refer you to concerning your injury, disease, and treatment;
- Assign to Shenandoah Podiatry all payments for medical services and/or supplies;
- Agree to pay any applicable service charges, collection agency costs or legal fees plus court costs should the account be declared overdue or delinquent;
- Hereby attest that the information on this form is true to the best of your knowledge.

Signature ____________________________________ Date _________________________

HIPPA PRIVACY POLICY

We are required by applicable federal and state laws to maintain the privacy of your protected health information. A copy of the Notice of Health Information Practices is posted for your review or you may request a copy at the front desk. By signing this notice you attest that you are aware of and understand the policy.

Signature __________________________________ Date _________________________

Medical Information

This information is important for our records and your health

Name______________________________ Date__________________

Why did you make this appointment? (Describe your foot problem)

____
____
____
____

How long has it been bothering you?_________________________________

Are you allergic or sensitive to:

( )Penicillin
( )Sulfa Drugs
( )Iodine
( )Ibuprofen
( )Latex
( )Other_____________
( )Codeine
( )Novocaine
( )Cephalosporins
( )Aspirin

Please list all of your medications (or give list to receptionist to copy):

____
____
____
____
____
____
____

Check ( ) any of the following you have, or have had a problem with:

( ) Heart attack
( ) Heart
( ) Congestive Heart Failure
( ) Diabetes
( ) Mitral Valve Prolapse
( ) High Blood Pressure
( ) Kidneys
( ) Cholesterol
( ) Neurological Disorder
( ) Stroke
( ) Asthma
( ) Arthritis
( ) Cancer
( ) Rheumatoid arthritis
( ) Acid Reflux (GERD)
( ) Liver
( ) Lungs
( ) Gout

Any other condition not mentioned ____
____

Have you had any of these surgeries:

( ) joint replacement ( ) appendix ( ) foot ( ) other surgery, what?___________
( ) heart by-pass ( ) gallbladder ( ) hysterectomy ______________________________
( ) heart valve ( ) tonsils ( ) C-section
( ) pacemaker ( ) vascular ( ) cancer, where?______________

Have you been admitted to the hospital in the past 12 months? For what?___________________
____

Family Physician____________________ Date you last saw this doctor____________________

Is there a family history of:
( ) heart problems ( ) arthritis ( ) diabetes ( ) circulation problems
( ) bunions ( ) flatfeet ( ) bleeding disorder

Do you smoke? Yes No # packs per day________ # of years______________

Did you previously smoke? Yes No # of years_____________

Do you drink alcohol or beer? Yes No # of drinks per week______________

Employment: ( ) sit at job ( ) stand at job ( ) varies

Check if you are currently having any of the following symptoms:

General	**Cardiovascular**	**Skin**
( ) chills	( ) chest pain	( ) easy bruising
( ) fever	( ) swelling in ankles	( ) sores that won't heal
( ) dizziness	( ) cold feet	( ) rash
	( ) leg cramps	( ) changes in moles

Muscle/Joints/Bones	**Neurological**	**Gastrointestinal**
( ) pain	( ) numbness	( ) poor appetite
( ) weakness	( ) burning/tingling	( ) diarrhea
( ) difficulty walking	( ) loss of coordination	( ) nausea/vomiting

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's signature____________________________ Date________________________