

# Welcome to Community Foot Care

## Patient Information

Name:

Date of birth:	Age:	SSN:	Date:
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Current address:

City:	State:	ZIP Code:
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Gender:	Email:
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Marital Status:    Single     Married     Widowed     Divorced     Separated

Spouse Name:	Spouse SSN (if Cardholder):	Spouse DOB:
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Home Phone:	Cell Phone:	Work Phone:
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## Insurance Information

Who is responsible for this account?	Relationship to patient:
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Primary Insurance Company:	ID#:
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Group #	Subscriber Name:	DOB:
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SSN:	Phone:	Network:
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Secondary Insurance Co:	Cardholder Name:	DOB:	SSN:
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## Emergency Contact

Name of a person not residing with you:

Relationship:	Home Phone:	Work Phone:
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## Assignment and Release

### Commercial Insurance Authorization.

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Community Foot Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Date:

\_\_\_\_\_  
Signature of responsible party.

**Medicare Authorization:** I request that payment of authorized Medicare benefits be made on my behalf to Community Foot Care for any services furnished me by my physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Date:

\_\_\_\_\_  
Signature of responsible party.

## Who do we thank for referring you?

Medical Doctor:

Phone Book:    AT&T?	Yellow Book?	Other?
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Patient: (Please provide name)

Other:

## Consent

I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my conditions. I give permission to acquire audiovisual documentation for diagnostic and teaching purposes. I understand that other practitioners such as surgical assistants, surgical residents, physician assistants, nurses, and other staff may assist the doctor in performing my treatment and I give my permission for them to do so.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of responsible party.

## MEDICAL HISTORY QUESTIONNAIRE

*Patient Instructions: Please read the **entire** form and fill in the blank or circle the correct answer.*

### GENERAL

What is your Primary Care/Internal Medicine doctor's name? \_\_\_\_\_  
What other doctors do you see? \_\_\_\_\_  
Allergies to Medications? \_\_\_\_\_  
When was the last time you had a general physical examination? \_\_\_\_\_  
Do you get enough exercise? ..... Yes No  
How would you describe your general health? ..... Excellent Good Fair Poor  
Have you ever been diagnosed with AIDS/HIV? ..... Yes No  
Do you have artificial heart valves or joints? ..... Yes No  
Have you ever been diagnosed with Hemophilia? ..... Yes No  
Have you ever been diagnosed with Hepatitis or Jaundice?..... Yes No  
Have you ever been diagnosed with Rheumatic Fever? ..... Yes No

### ARTERIAL PROBLEMS

*Certain "risk factors" put you at increased risk for developing arteriosclerosis (hardening of the arteries) which is the main cause of heart attacks, strokes and amputations. As a result you may not heal your foot surgery or you may develop complications from your present condition. That is why we ask the following questions.*

Risk Factors:

Do you now or have you ever smoked **tobacco**? ..... Yes No  
At what age did you start? \_\_\_\_\_  
At what age did you quit? \_\_\_\_\_  
How much do you smoke now? \_\_\_\_\_  
Do you have **high blood pressure**? ..... Yes No  
How old were you when it was first diagnosed? \_\_\_\_\_  
Have you ever had a major or minor stroke? ..... Yes No  
If so, please comment \_\_\_\_\_  
Please list your blood pressure medications, doses and frequency: \_\_\_\_\_  
\_\_\_\_\_  
Have you ever had heart trouble?..... Yes No  
Type of heart trouble? heart attack      abnormal rhythm      heart failure  
Date? \_\_\_\_\_  
Do you have a pacemaker?..... Yes No  
Please list hospitalizations for the heart problems, including dates: \_\_\_\_\_  
\_\_\_\_\_  
Please list your heart medications, doses and frequency:  
\_\_\_\_\_  
Do you take medications to fight **cholesterol**? ..... Yes No  
Please list your cholesterol medications, doses and frequency  
\_\_\_\_\_  
Do you take blood thinners? Yes No What kind? Aspirin Plavix Coumadin Other:  
Why do you take blood thinners? \_\_\_\_\_  
What is the most you have ever weighed? \_\_\_\_\_ What do you weight now? \_  
Have you ever been told that you have trouble with your circulation? ..... Yes No  
Do you get cramps or fatigue in your legs when you walk?..... Yes No  
Right leg      Left leg      Both legs  
Do your feet hurt at night?..... Yes No  
Have you ever had any sores or ulcers on your feet, legs, or toes? .... Yes No  
Have you ever been treated or operated upon for circulation problems? Yes No

**VENOUS PROBLEMS**

*Although varicose veins usually don't interfere with foot problems, other diseases of the veins may put you at risk for developing ulcers or blood clots. The answers to these questions will help your doctor as he cares for your foot problems.*

- Do you have varicose veins? ..... Yes No  
Who in your family has varicose veins? \_\_\_\_\_
- Do you have swelling of your ankles? ..... Yes No  
Does the swelling go away at night or does it continue? \_\_\_\_\_  
How long have you had the swelling? \_\_\_\_\_  
What do you do about it? Take diuretics (water pills) Use elastic compression stockings Other: \_\_\_\_\_
- Have you ever had a "blood clot" in your leg(s)?.....Yes No  
If so, were you given blood thinners?..... Yes No  
Were you put in the hospital? ..... Yes No  
Did it happen after a pregnancy or operation?.....Yes No
- Have you ever had an ulcer on your ankle? .....Yes No
- Have you ever bled from a varicose vein?.....Yes No
- Do you have any discoloration of your ankles? .....Yes No  
If so, when did it begin? \_\_\_\_\_
- Have you ever had a "blood clot" to the lung or heart? ..... Yes No  
How long were you treated for it? \_\_\_\_\_
- Do you have any "bleeding or clotting tendencies"? ..... Yes No

**DIABETES**

*Diabetes is a growing health care problem in America and poses special problems for Podiatry patients. By knowing more about your Diabetes your doctor can take better care of your feet and help you to take better care of yourself.*

- Do you have diabetes ("sugar")? ..... Yes No  
How old were you when you were diagnosed with diabetes? \_\_\_\_\_  
How often do you (or someone) check your blood sugar?  
Every day More than once a day Other: \_\_\_\_\_  
What do your morning blood sugars measure? \_\_\_\_\_
- Do you take pills to control your blood sugar? ..... Yes No
- Do you take insulin to control your blood sugar?.....Yes No  
Do you know what **your** HGBA1c is? .....Yes No
- Who in your family has diabetes? \_\_\_\_\_  
Have they ever had a major health care problem because of their diabetes? .... Yes No  
If so, what kind of problem? \_\_\_\_\_
- Have you ever had any trouble with your vision?.....Yes No
- Have you ever had laser treatment for your eyes? ..... Yes No
- Do you have any trouble with your kidneys?.....Yes No
- Do you have any numbness, tingling, or burning of your feet? ..... Yes No

**AND FINALLY...** Is there anything else you would like to tell me about your health or other medications not listed above? \_\_\_\_\_

\_\_\_\_\_  
Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Thank you for answering these questions. Working together, we can provide you with quality care.