Date:_____

Last Name _____ First _____ Middle _____

Name I am called_____ Date of Birth _____

Mailing Address (if PO Box provide physical address as well)

_____

City _____ Zip Code _____

Home Phone _____ Mobile Phone_____

Email address _____

Choose one: SINGLE MARRIED DIVORCED SEPARATED WIDOW(ER)

If married, spouse name _____

Primary Care Physician _____ Date Last Seen_____

Primary Insurance Company _____

Secondary Insurance Company _____

Tertiary Insurance Company _____

Consent to Communicate

☐ The contact information provided above is correct and I consent to allow communication from Habersham Podiatry. Preferred: *Home Phone* *Mobile Phone* *Text* *Email*

☐ I consent that any contacts listed below are also able to receive messages from this office.

EMERGENCY CONTACT _____ DOB _____

RELATIONSHIP_____PHONE _____

OTHER CONTACT _____DOB _____

RELATIONSHIP _____PHONE _____

Patient Signature _____ Date _____

Habersham Podiatry

Disclosure/Consent/Financial Policy

Patient Name_____Date of Birth_____

Assignment of Insurance Benefits:

____ I hereby authorize direct payment of my insurance benefit to Habersham Podiatry or the physician individually for services rendered to me or my dependents by the physician or under her supervision. Proof of valid insurance MUST be provided the same day of my visit. I understand that this is my responsibility to know my insurance benefits and whether the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any copay or balance due that Habersham Podiatry is unable to collect from my insurance carrier for whatever reason.

- We do NOT file auto, general liability, or homeowner's insurance
- It is your responsibility to notify us of any changes in your insurance

Medicare/Medicaid Insurance Benefits:

____ I certify that the information given to me in applying for payment under these programs is correct. I authorize release of any of my records that these programs may request. I hereby direct payment of my benefits to be made directly to Habersham Podiatry or the physician on my behalf.

Lab/diagnostic Services:

____ I understand that I may receive a separate bill if my medical care includes labs or any other diagnostic services. I further understand that I am financially responsible for any copay or balance due for these services if they are not covered by my insurance carrier for whatever reason.

_____Payment & Financial Policy

- **We DO NOT bill insurance for supplies other than diabetic shoes, cast braces and ankle braces. Payment for arch supports, pads and other supplies are due the same day they are dispensed.**
- **Any outstanding balance must be paid before your next appointment.**
- **If you do NOT have insurance, payment is due in full the SAME day as your appointment.**
- **WE accept CASH, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, and CARE CREDIT**
- **There will be a $35.00 charge for returned checks**
- **Past due accounts will be subject to our collections process**

If you are unable to pay your balance in full, please contact Kristie at our office to set up payment arrangements.

Patient Signature_____Date_____

Guarantor Signature_____Date_____

REASON FOR VISIT

Name_____Date_____

Reason for Visit including……**RIGHT LEFT ANKLE FOOT TOENAILS**

Ingrown Nails	Bunion	Hammertoes	Athlete's Foot
Fungal Nails	Heel Pain	Burning Feet	Diabetic Foot Check
Callus	Pain	Sprain	Wart

Other_____

How long has the problem been present?

_____ Days _____Weeks _____ Months _____Years

Circle type of pain:

Sharp Shooting Dull Aching Tingling Numb Tender Sore Sensitive

Describe any related injury_____

_____

Underline or list everything you have tried to treat the problem:

Ice	New Shoes
Heat	Ace wrap
Soaking in hot water	Advil, Aleve, Tylenol
Arthritis Cream	Trimming
Dr Scholl's arch supports/gel heel pad	Callus remover
Other over the counter arch supports	Stretching
Custom Orthotics	Rolling ball under arch

Does anything help the condition? _____

Does anything worsen the condition?

_____

List any other doctor(s) who have treated you for this condition.

_____

_____

Past Medical History (Check all that apply) **NAME:**_____

☐ **No Past Medical History**

Bone/Joint

☐ Arthritis: *Osteo Rheumatoid Psoriatic Gouty*
☐ Fractures: *Back Neck Arm Leg Hip Ankle Foot*
☐ Bulging Disc
☐ Chronic Lower Back Pain
☐ Connective Tissue Disorder
☐ Degenerative Disc
☐ Fibromyalgia
☐ Gout
☐ Lupus
☐ Motor Vehicle Accident
☐ Osteopenia (low bone mass)
☐ Osteoporosis
☐ Scleroderma
☐ Sjogren's
☐ Spinal Stenosis

Blood/Circulatory

☐ Blood Clotting Disorder
☐ DVT/PE Blood Clots
☐ Hemophilia
☐ HIV Positive
☐ Lymphedema
☐ Peripheral Vascular Disease
☐ Raynauds
☐ Sickle Cell Disease
☐ Varicose Veins
☐ Venous Insufficiency

Liver/Pancreas/Kidney

☐ Chronic Pancreatitis
☐ Cirrhosis
☐ Hepatitis
☐ Kidney Disease or Failure
☐ Liver Disease/Disorder
☐ Receiving Dialysis

Endocrine

☐ Diabetes Type I
☐ Diabetes Type II
☐ Pre-Diabetes
☐ Excessive Sweating
☐ Hyperparathyroidism
☐ Hypothyroidism
☐ Hyperthyroidism

Recent HgA1C_____

Lungs

☐ Asthma
☐ Chronic Bronchitis
☐ COPD
☐ Emphysema
☐ Home BiPap/CPAP
☐ Oxygen Therapy
☐ Sleep Apnea

Skin

☐ Dermatitis
☐ Eczema
☐ Pressure Ulcer
☐ Psoriasis
☐ Skin Ulcer or Wound
☐ Venous wound

Gastrointestinal

☐ Barretts Esophagus
☐ Celiac Disease
☐ Crohn's Disease
☐ Gastritis
☐ Stomach Ulcer
☐ Ulcerative Colitis

Heart

☐ Angina (chest pain)
☐ Atrial Fibrillation
☐ Heart Attack Year_____
☐ High Blood Pressure
☐ High Cholesterol
☐ Irregular Heart Rhythm

Cancer

☐ Breast Cancer
☐ Colon Cancer
☐ Leukemia
☐ Liver Cancer
☐ Lung Cancer
☐ Lymphoma
☐ Multiple Myeloma
☐ Ovarian Cancer
☐ Prostate Cancer
☐ Uterine Cancer
☐ Other
_____

Neurological

☐ ADD/ADHD
☐ Alzheimer's
☐ Cerebral Palsy
☐ Dementia
☐ Depression
☐ Drop Foot
☐ Epilepsy
☐ Multiple Sclerosis
☐ Numbness in feet or hands
☐ Parkinson's
☐ Restless Leg Syndrome
☐ Sciatica
☐ Seizure Disorder

Eyes/Ears/Head

☐ Glaucoma
☐ Migraines
☐ Problems with hearing
☐ Problems with vision
☐ Vertigo (dizziness)

Social History

Hobbies/Sports/Exercise _____

Type of daily footwear: ATHLETIC DRESS NONSLIP WORKBOOTS

If employed, occupation _____ FULL TIME PART TIME

If employed, choose one: MANUAL LABOR DESK JOB STANDING COMBINATION

Cigarette/Tobacco Current Use YES NO If cigarette use, years smoked _____ # packs per day ___

Previous Surgeries

- ☐ Appendectomy
- ☐ Back
- ☐ Cataracts
- ☐ Fracture
- ☐ Foot/Ankle (detail) _____
- ☐ Gall Bladder
- ☐ Gastric Bypass
- ☐ Heart Stents/Bypass
- ☐ Hip Replacement L R
- ☐ Hysterectomy
- ☐ Knee Replacement L R
- ☐ Shoulder
- ☐ Tonsils/Adenoids

Specialty Care Provider Information (name, city)

- ☐ Cardiologist _____
- ☐ Chiropractor _____
- ☐ Endocrinologist _____
- ☐ Orthopedist _____
- ☐ Pain Management _____
- ☐ Rheumatologist _____
- ☐ Vascular Specialist _____

Allergies

- ☐ Aspirin
- ☐ Cipro
- ☐ Codeine
- ☐ Erythromycin
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Tylenol
- ☐ Other

_____

Medications (OTC Medications, inhalers, eye/ear drops, supplements, injectables)

Or request a list from your pharmacy and email to: kristie@habershampodiatry.com

Medication Name	Dosage	Frequency	Route (oral, inhaled, injection)	Condition for which Medication is Prescribed

Preferred Pharmacy _____ City _____