New Patient Forms

Patient Name ______________________________ Today's Date: ____/____/ _____

Date of Birth: ____/_____/____ Age: ____ Social Security #: _____-____-_______

Sex: Male Female Height ________ Weight ________ Shoe Size ________

Home Address: _________________________ City/State: _____________ Zip: ________

May we leave a message?

Home Phone #: (____)-______-______ Yes No

Work Phone #: (____)-______-______ Yes No

Cell Phone #: (____)-______-______ Yes No

E-Mail: _______________________ Primary Language: _____________

Pharmacy: _________________ Location: ____________ Phone #: (___)-_____-______

Do you have a legal Guardian of Attorney? Yes No

If yes, Name: ____________ Relationship:__________ Phone #: (___)-_____-_______

Emergency Contact:______________ Relationship ________ Phone #: (___)-____-______

Who is responsible for payment? ______________ Relationship to Patient: ___________

Address: ____________ City/State: ________ Zip: _______ Phone #: (___)-____-______

Who referred you to us? ____

Insurance Information

Primary Insurance Company Name: ______________________________

Address: ____________ City/State: __________ Zip: _______ Phone #: (___)-____-____

Insured Name: ____________ Date of Birth:__________ Employer: ______________

Contract #: ____________________ Group #: __________________________

Medical Information

Primary Care Doctor: __________________________ Phone #: (___)-_____-______

Date last seen by primary care doctor: ______________

For 65+ years of age, have you ever had a Pneumococcal vaccination? Yes No

For 65+ years of age, have you had a Flu vaccination within the last year? Yes No
If NO, please list reason: ____

Medications you are currently taking (Include prescriptions, over-the-counter meds, and herbal supplements):

Name	Dose	Name	Dose

Allergies: No Known Allergies

______ ______ ______ ______ ______
______ ______ ______ ______ ______

Please List All Prior Surgeries:

Type of Surgery	Date	Type of Surgery	Date

Social History (Circle all that apply):

Use of Alcohol: Never No Longer Use History of Alcohol Abuse

Current Use/Type: ______ Rare Occasional Moderate Daily

Use of Tobacco: Never Quit/How long ago?______ Smoke __ packs/day for ____ years

Employer: ______________________ Occupation: ______________________

How often are you on your feet at work?: 10% 25% 50% 75% 100%

Exercise: Never Rare Occasional Weekly Several times a week Daily

Types of exercise: ______________________________

Please circle if you have you ever had any of the following...

Acid Reflux
Anemia
Arthritis
Asthma
Back Pain
Bladder Infections
Abnormal Bleeding
Blood Clots
Blood Transfusion
Bronchitis
Cancer
Diabetes: Type 1 or 2

Fibromyalgia
Gout
Heart Attack
Heart Disease/ Failure
Hepatitis
HIV+/AIDS
High Blood Pressure
Kidney Disease
Liver Disease
Low Blood Pressure
Migraine Headache
Mitral Valve Prolapse

Neuropathy
Open Sores
Pneumonia
Polio
Rheumatic Fever
Sickle Cell Disease
Skin Disorder
Sleep Apnea
Stomach Ulcers
Stroke
Thyroid Disease
Tuberculosis

Other Conditions: ______________________________

Where is the pain located? Please mark on the pictures below... Please Circle Answers to Questions below and describe if needed...

Top of Foot	Left	Bottom of Foot	Bottom of Foot	Right	Top of Foot
Inside of Foot		Outside of Foot	Outside of Foot		Inside of Foot

Current Problem

What specific problem(s) brought you to the office today? ______________________________

How long ago did this problem start? ______Days / Weeks/ Months/ Years

Did your pain or problem.... Begin all of a sudden   Gradually Developed Over time

How would you describe your pain? No pain   Sharp   Dull   Aching   Radiating   Itching   Stabbing
Other__________________

How would you rate your pain on a scale of 1-10? ______________________
Since your problem has begun has it... Stayed the same   Become worse   Improved

What makes your problem feel worse? ________________________________

What makes your problem feel better? ________________________________

What treatments have you had? ____________________________________

Has the problem affected your lifestyle and ability to work? Yes   No

Was this problem caused by an injury? Yes   No   **If yes was it work related or a motor vehicle accident?** Yes   No

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and staff of changes in my medical status.

____   ____
Print name of patient, or guardian (& relationship)   **Signature**

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION TO FRIENDS OR FAMILY MEMBERS

Patient Name____ Date of Birth________________

CONSENT

I request Mid Plains Podiatry to release protected healthcare information to:

Name____

Relationship to Patient____

Name____

Relationship to Patient____

Name____

Relationship to Patient____

This request and authorization applies to: (please check below)

__All healthcare information (Medical and Billing)

__Healthcare information relating to the following treatment, condition or dates:

____

____

__Other____

I understand that the designation applies only to Mid Plains Podiatry.

Patient Signature____Date Signed____________

REVOCATION/TERMINATION

I request to revoke/terminate the designation made above.

Patient Signature____Date Signed____________

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PODIATRIST

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