ELITE PODIATRY

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WELCOME TO OUR OFFICE!

NEW PATIENT INTAKE FORM

Name : _____ Gender _____M_____F

Date of Birth _____Age_____ Social Security #_____

Address:_____City:_____State:_____Zip_____

Home Phone #_____ Work Phone #: _____Cell Phone:_____

Emergency Contact: _____Phone: _____Cell Phone:_____

E-mail Address:_____ Primary Spoken Language_____

Primary Care Physician: _____ Referred by:_____

Cardiologist:_____Endocrinologist:_____

Nephrologist:_____Rheumatologist:_____

Please describe your foot/ankle problem (include date of injury if applicable)

_____

_____

_____

How long has the problem been present? _____

Have you had any treatment or taken anything for it? _____

Have you seen someone for this already? ____No _____Yes Whom? _____

Have you had any prior foot/ankle problems? If yes, please describe: ____No _____Yes

ALLERGIES

Please check all allergies:

_____ Medications:_____

_____ Foods: _____

_____ Tapes or Topical Skin Sensitivity _____ Other: _____

What types of reactions have you experienced?

_____

_____

MEDICATIONS

Please list all medications and the dosages:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PERSONAL MEDICAL HISTORY

***** Check those that apply to you now or have applied to you in the past *****

	Frequent Headache/Migraines		Anemia/Blood Disorders
	Liver Disorder		Pneumonia
	Kidney Disease		Drug/Alcohol Abuse
	Dialysis M W F or T TH SA		Epilepsy or Seizures
	Diabetes Average Blood Sugar _____		Prolonged Bleeding Time
	Asthma		Stomach/ Ulcer Disorder
	Emphysema		Thyroid/Parathyroid Disease
	Heart Trouble		High Blood Pressure
	Stroke		Arthritis
	Chest Pain on Mild Exertion		Psychiatric Treatment
	Gout		Emotional Problems/Tension
	BLOOD CLOTS		Asthma/ Hay Fever / Shortness of Breath
	Tumor/Abnormal Growth/ Cancer		Sexually Transmitted Disease
	Ear, Nose, Throat Disorder		Prostate Disorder
	Hepatitis/ HIV		Other

PATIENT INFORMATION

Do you smoke currently? _____Yes _____No How many packs per day? _____ For how many years?____

Have you smoked previously? _____Yes _____No When did you quit?_____

Number of caffeine drinks per day? _____ Amount of alcohol consumed per week _____

For women only: Are you pregnant? _____ How many months?_____

Please complete the following:

Height: _____ Weight:_____ Shoe size: _____ Occupation:_____

Is there any other information you would like us to be aware of: _____No _____Yes

Please describe:_____

MEDICAL CONDITIONS

Diabetes	High Blood Pressure	Heart Disease	Heart Murmur	Heart Valve	Siezures
Asthma	Rheumatic Fever	Hepatitis	Stroke	Gout	Anemia
Stomach Ulcers	Liver Disease	Circulation	Cancer	Infections	HIV
Nerve Problems	Thyroid	Kidney Disease	Bleeding	Scarring	Fever
Tuberculosis	Hormones	Arthritis	Chills	Seizures	

Muscular/Skeletal

Weakness of muscles	Joint Pain	Joint Redness	Joint Swelling
Morning Stiffness	Leg Cramps	Back Pain	
Muscle Tenderness	Neck Pain	Stiffness	Difficulty with walking

Neurological

Burning in feet Tingling in feet or toes Numbness Tremors

Psychiatric: Addictions Attempted Suicide Depression Memory loss Panic Attacks

I hereby authorize direct payment of surgical and medical benefits on my behalf to the provider of these services that I would otherwise be payable to me if I did not make this assignment. I understand that I am personally responsible to the physician for charges not covered by my insurance agreement. I also understand that if my account becomes delinquent, I will be responsible for any costs of collection of my account, including collection fees and attorney costs. A $5.00 per month re-invoicing fee may apply to all accounts 60 days past due. I permit a copy of this assignment to be used in lace of the original for purpose of billing.

The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital generated. Also, I herby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition, to use x-ray examination, or photographs as necessary.

I give Elite Podiatry Inc. permission to obtain and release medical information to insurance companies and referring physicians. I have read the following and understand and agree to Elite Podiatry Inc. office policy.

_____ _____

Date **SIGNATURE OF PATIENT OR LEGAL GUARDIAN**

** If not patient, relationship to patient

___Parent ___Power of attorney ___Legal Guardian ___Other