

# W E L C O M E

PATIENT INFORMATION	
Date	_____
Patient	_____
Address	_____
City	_____ State _____ Zip _____
Sex	<input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birthdate _____
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced
Patient SS #	_____
Occupation	_____
Employer	_____
Employer Address	_____ _____
Employer Phone #	_____
Spouse's Name	_____
Spouse's Birthdate	_____ SS # _____
Spouse's Occupation	_____
Spouse's Employer	_____
Who may we thank for referring you? _____	

PHONE NUMBER	
Home	_____ Work _____
Best time and place reach you _____	
IN CASE OF EMERGENCY, CONTACT	
Name	_____ Relationship _____
Home	_____ Work _____

INSURANCE	
Who is responsible for this account? _____	
Relationship to Patient _____	
Insurance Co. _____	
Group # _____	
Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Subscriber Name _____	
Birthdate	_____ SS # _____
Relationship to Patient _____	
Insurance Co. _____	
Group # _____	
ASSIGNMENT AND RELEASE	
I, the undersigned certify that I (or my dependent ) have insurance coverage with _____ and assign directly to Dr. <u>HAAS</u> 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.	
x _____	
Responsible Party Signature _____	
Relationship	_____ Date _____
MEDICARE AUTHORIZATION	
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. <u>HAAS</u> for any services furnished me by that 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 noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.	
Beneficiary Signature _____ Date _____	

PODIATRIC HISTORY		
What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.) _____ _____ _____	Is there any personal or family history of diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No  Your Occupation _____ Cigarette/Tobacco Use _____ Years Smoked _____	Please indicate which foot problems you now have or have had in the past. Ankle Pain _____ Yes _____ No Athlete's Foot _____ Yes _____ No Bunions _____ Yes _____ No Corns and Callouse _____ Yes _____ No Cramps or Numbness _____ Yes _____ No In Feet or Legs _____ Yes _____ No Flat Feet _____ Yes _____ No Foot or Leg Cramps _____ Yes _____ No Heel Pain _____ Yes _____ No Ingrown Toenails _____ Yes _____ No Plantar's Warts _____ Yes _____ No Swelling in Ankles or Feet _____ Yes _____ No Tired Feet _____ Yes _____ No
Have you ever been to a Podiatrist before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list. Name _____  Last visit _____	Athletic activities in which you participate (please list and indicate frequency) _____ _____	

## MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies to Anesthetics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies to Medicine or Drug	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Foot or Leg Cramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valves or Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis or Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swelling in Ankles, Feet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	kidney Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tired Feet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Phlebitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Phlebitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weight Loss, Unexplained	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ear Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Surgeries you have had \_\_\_\_\_

Hospitalization other than for the Surgeries Listed \_\_\_\_\_

Family Physician \_\_\_\_\_ Last visit date \_\_\_\_\_

Are you now, or have you been, under any other doctor's care for any reason over the past two years? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain \_\_\_\_\_

MEDICATIONS	
Include prescriptions, over-the-counter medications and vitamins _____	
Pharmacy Name(s)	_____
Pharmacy phone(s)	_____
Do you take oral contraceptives?	<input type="checkbox"/> Yes <input type="checkbox"/> No

ALLERGIES	
<input type="checkbox"/> Adhesive/Tape	<input type="checkbox"/> Local
<input type="checkbox"/> Anticoagulant	<input type="checkbox"/> Anesthetics
<input type="checkbox"/> Therapy	<input type="checkbox"/> Novocaine
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Seafoods
<input type="checkbox"/> Demerol	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	
Other	_____

CONSENT	
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 procedure as may be deemed necessary in the diagnosis and /or treatment of my feet.	
Patient's Signature _____	Date _____