WELCOME TO OUR OFFICE

Name:
Address:
Apt:_____
City,State,Zip: _____
Cell/home _____
Work _____
Status:
Sex: **F** Birth date: _____
Social Security: _____
E-Mail _____
Employer: _____
Address: _____
City, state, zip: _____
Phone: _____

Have you been to a Podiatrist before? ☐ Yes
How did you find out about our office?

_____

Athletic activities you participate frequently:
_____Shoe size_____

What is the main problem with your feet or ankle for your visit today and when did it begin?

Date of onset:_____/_____/_____

Ankle pain	☐ Yes	☐ No
Athletes foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns,calluses	☐ Yes	☐ No
Cramps or numbness	☐ Yes	☐ No
Flat feet	☐ Yes	☐ No
Heel pain	☐ Yes	☐ No
Ingrown toenails	☐ Yes	☐ No
Plantar warts	☐ Yes	☐ No
Swelling in foot or ankle	☐ Yes	☐ No
Tired feet	☐ Yes	☐ No

Other: _____

INSURANCE INFORMATION

Primary:
Name responsible for this account? _____
Relationship to patient: ☐ self ☐ spouse ☐ parent ☐ other
Birth date of insured: _____ SS# of insured: _____
Insurance co: _____
Policy#: _____ Group#: _____

Secondary:
Is patient covered by other insurance? ☐ Yes ☐ No
Name responsible for this account? _____
Relationship to patient: ☐ self ☐ spouse ☐ parent ☐ other
Birth date of insured: _____ SS# of insured: _____
Insurance co: _____
Policy#: _____ Group#: _____

ASSIGNMENT AND RELEASE FOR INSURANCE INFORMATION

I, the undersigned certify that (or my dependent) have insurance coverage with _____and assign directly to Dr. Maria K. Wilson all insurance benefits. If any, otherwise payable to me for services rendered, I understand that I AMFINANCIALLY 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.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Maria K. Wilson for any services furnished. 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 request that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept that 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.

I CERTIFY THAT THE INFORMATION GIVEN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE MY PERMISSION TO DR. Marla K. Wilson TO ADMINISTER AND PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FEET OR ANKLES.

Signature _____ Date: _____

PLEASE COMPLETE OTHER SIDE ➡ ➡ ➡

MEDICAL HISTORY

AIDS/HIV	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Leg/Foot Ulcers	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No	Organ Transplant	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Blood Clot	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Peripheral Vascular Dz	☐ Yes	☐ No
Coronary Artery Disease	☐ Yes	☐ No	Polio	☐ Yes	☐ No
Deep Vein Thrombosis	☐ Yes	☐ No	Pulmonary Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Pulmonary Embolism	☐ Yes	☐ No
Dyslipidemia	☐ Yes	☐ No	Raynaud's Disease	☐ Yes	☐ No
Edema	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No	Seizure/Epilespy	☐ Yes	☐ No
Foot Deformity	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Frost Bite	☐ Yes	☐ No	Substance Abuse	☐ Yes	☐ No
Gout	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No			
Hernia	☐ Yes	☐ No			

MEDICAL HISTORY

Name: **DOB:**

Current Physician Name: _____ Date Last Seen: _____/_____/_____

Current Pharmacy Name: _____

CURRENT/PAST MEDICATIONS

name	dose	frequency	starting	ending	physician	purpose

SURGICAL PROCEDURES

date	procedure	physician	hospital	notes

ILLNESS/ALLERGY

illness/allergy	physician	treatment notes/description of reaction

SOCIAL HISTORY

	Yes or No		
Cigarette/ Cigar/ Chew		Packs per day:	
Alcohol		How often	
Caffeine/ Coffee		Cups per day	
Illicit drugs		How often	