PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. PLEASE PRINT CLEARLY. All information will be confidential.

Date _____ Who is your medical doctor _____ Date of last visit to your doctor _____

Patient Given Name _____

SSN _____ Date of Birth _____ Age _____

Patient is: _____ Minor ____ Single ____ Married ____ Divorced/Sep ____ Widowed Sex: ____ M _____ F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Employer _____ Employer Address _____

(if applicable)
Spouse's Name _____ Date of Birth _____ SSN _____

Spouse's Employer _____ Is he/she our patient? ____ Y _____ N

Person to contact in case of emergency _____ Phone _____

How did your hear about our office _____

Responsible Party (Use "Same" when applicable)

Name of person responsible for account _____ Relationship _____

SSN _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Employer _____ Employer Address _____

IS THIS PERSON CURRENTLY A PATIENT AT OUR OFFICE? _____ Yes _____ No

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Insurance Information (Primary Plan)

Insurance Company _____

Policy Holder's Name _____ Date of Birth _____ Relationship to patient _____

ID Number _____ Group # & Name _____

*Do you have any additional insurance? _____ Yes _____ No If yes, please complete the following:

Insurance Company _____

Policy Holder's Name _____ Date of Birth _____ Relationship to patient _____

ID Number _____ Group # & Name _____

WE WILL NEED TO MAKE COPIES OF YOUR INSURANCE CARD(S)

PATIENT HISTORY

Date: _____ Patient Name _____

Date of Birth: _____ Are you a diabetic? ___ yes ___no If yes, are you on Insulin? ___yes ___no

Please describe the problem that brought you to our office today and its cause if you know it: _____

_____

My main problem is ___on the left foot ___on the right foot ___on both feet Other _____

How long have you had this problem/pain? _____ days weeks months years (please circle)
(give # of days/wks/mos.)

Please indicate the severity of your pain/discomfort: ___None ___Mild ___Moderate ___Strong ___Severe

My pain/discomfort is:
__ Shooting pain __ Burning pain __ Itching Other (describe)_____
__ Throbbing pain __ Aching pain __ Tingling _____
__ Sharp pain __ Dull pain __ Numbness _____

My pain/problem occurs: __ when walking __ when not walking __ with shoes __ without shoes __ all the time

Other (explain) _____

Describe any self-treatment you have performed _____

Have you been treated by anyone else for this problem? __ yes __ no When?_____By whom?_____ What was done? _____

Is this an injury? __yes __no If yes, date of injury: / / . Is the injury work-related? __ yes __no

_____

Do you have or have you ever been treated for:

☐ Stroke	☐ Heart Attack	☐ High Blood Pressure
☐ Phlebitis	☐ Vascular Disease	☐ A Heart Condition
☐ Diabetes	☐ Poor Circulation	☐ Headaches
☐ Hepatitis	☐ Liver Disease	☐ Anemia
☐ Gout	☐ Arthritis	☐ Osteoporosis
☐ Sciatica	☐ Rheumatic Fever	☐ Lyme's Disease
☐ Alzheimer's	☐ Keloid/Thick Scar	☐ Hearing/Ear Disorder
☐ Epilepsy	☐ Nerve Disorder	☐ Psychiatric Disorder
☐ Glaucoma	☐ Kidney Disease	☐ Thyroid Problem
☐ Asthma	☐ Lung Disease	☐ Tuberculosis
☐ Cancer	☐ Stomach Ulcer	☐ ***NONE of these***

☐ Other(s): _____

Do you have vascular grafts? *(If yes, explain below)* ☐ Yes ☐ No
Do you have joint implants? *(If yes, explain below)* ☐ Yes ☐ No
Do you have replacement heart valves? ☐ Yes ☐ No
Are you now under active chemotherapy? ☐ Yes ☐ No
Have you had any surgery? *(If yes, explain below)* ☐ Yes ☐ No

Had Surgery for: on date of: w/ complications of:

_____ _____ _____
_____ _____ _____

Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:
(Check the answer box that applies)

	No	Yes		No	Yes
Penicillin	☐	☐	Empirin, Tylenol *(if yes, circle)*	☐	☐
Other antibiotics *(list below)*	☐	☐	Advil, Aleve, or Motrin *(circle)*	☐	☐
Morphine	☐	☐	Other pain remedies *(list below)*	☐	☐
Codeine	☐	☐	Sulfa drugs	☐	☐
Demerol	☐	☐	Adhesive tape	☐	☐
Other narcotics *(list below)*	☐	☐	Shrimp, Iodine, or Merthiolate	☐	☐
Novocaine	☐	☐	Any other drugs or medications.	☐	☐
Other anesthetics *(list below)*	☐	☐	*Others:* _____		
Aspirin	☐	☐			

List family members who have had:

Diabetes_____ Foot Problems _____
Arthritis_____ Heart Attack _____
Stroke_____ High Blood Pressure _____
Cancer _____ Birth Defects_____

# of childbirths ___ Are you currently pregnant? ☐ Yes ☐ No
Are you slow to heal after cuts? ☐ Yes ☐ No
Any abnormal bruising, bleeding or scarring? ☐ Yes ☐ No
Do you smoke now? ☐ No ☐ Yes Packs/day ___ Years___
Did you ever smoke? ☐ No ☐ Yes Packs/day ___ Years___
If you quit, when did you do so? _____
Alcoholic beverages? *(Circle one)* None Rarely Moderately Daily Quit
Recreational Drugs? *(Circle one)* None Rarely Moderately Daily Quit

Are you currently taking any medications? List below! ☐ Yes ☐ No

List: Medications Dose? How Often?

_____
_____
_____
_____
_____

Did you previously or do you now wear:
Shoe Inserts? [Y] [N] Still using them? [Y] [N] Do or did they help? [Y] [N]
Orthotics? [Y] [N] Still using them? [Y] [N] Do or did they help? [Y] [N]
The orthotics were obtained from: ☐ Another Podiatrist ☐ An Orthopedist
☐ A Physical Therapist ☐ A Chiropractor ☐ Other: _____
Percent of waking hours spent on your feet? [20%] [40%] [60%] [80%] [100%]
List the sports/type of dance your are active in: _____

What is your height? _____ Weight _____ Shoe Size _____

_____
SIGNATURE Date

Donald E. Robinson, DPM PC
AUTHORIZATIONS

Assignment and Release:
I, the undersigned, certify that I (for my dependent) have insurance coverage with

_____

and assign directly to Donald E. Robinson DPM PC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for costs not covered or reimbursed b y third party payors. I hereby authorize the doctor to release al information, including information regarding an illness that may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, and AIDS, necessary to secure payment of benefits to any responsible party. I authorize the use of this signature on all insurance submission, and certify that the information provided here is true and correct. In Medicare assignment 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 no-covered services.

_____
Signature of Responsible Party

_____
Relationship to Patient Date

Consent to Treat
I request and authorize the physician and his staff to provide me with treatment and to perform any procedure now contemplated, or such additional procedures as my doctor may deem necessary. I authorize my insurance company and/or the Social Security Administration (Medicare) to disclose information regarding my insurance coverage, including but not limited to verification of my identification number, effective dates and type coverage.
The undersigned certifies that he/she has read and understands the foregoing and is the patient or is duly authorized by that patient as the patient's general agent to execute the above and accepts its terms. It is further understood that this release remains in effect for while I am under the physician's care unless otherwise revoked.

_____
Patient's Signature Date

_____
Signature of Person Authorized to Sign in Lieu of Patient Date

Acknowledgement of Receipt of Notice of Privacy Practices
I acknowledge that I was provided a copy of the Notice of Privacy and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____
Patient's Name (Please Print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature