

DATE: _____

TROY PODIATRIST, P.C.

NAME: _____ D.O.B: ____/____/____

LAST 4 OF SS# - _____ GENDER: Female Male PRIMARY LANGUAGE: _____

MARITAL STATUS: Never Married Married Divorced Separated Widowed

RACE: White Black/African American Asian American Indian/Alaska Native Native Hawaiian/Other Pacific

ETHNICITY: Non Hispanic or Latino Hispanic or Latino

ADDRESS: _____ CITY, STATE: _____ ZIPCODE: _____

DAY / WORK / CELL PHONE: _____ - _____ - _____ NIGHT / HOME PHONE: _____ - _____ - _____

*May we leave a voice mail message containing personal information? _____

E-MAIL ADDRESS: _____ EMPLOYER/TITLE: _____

SYMPTOMS & REASONS FOR VISIT: Ankle Arch Athlete's Foot Bunions Circulatory Problems Corns/Calluses Cramps Flat Feet Foot Fungus Heels Ingrown Toenail Legs Numbness Pain/Swelling Skin Rash/Allergies Toes Varicose Veins Warts Injury

PATIENT'S MEDICATIONS (CAN PROVIDE LIST): None

PATIENT'S ALLERGIES TO MEDICATIONS: No Known Allergies Sulfa Codeine Penicillin Latex

Other allergies: _____

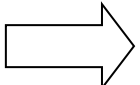
PATIENT'S MEDICAL HISTORY: No Significant Medical History

- | | |
|---|--|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> High Blood Pressure (Hypertension) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Cholesterol (Hypercholesterolemia) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hyperthyroidism (Over Active Thyroid) |
| <input type="checkbox"/> Atrial Fibrillation (A-Fib) | <input type="checkbox"/> Hypothyroidism (Under Active Thyroid) |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Multiple Sclerosis (MS) |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Diabetes Type I | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Diabetes Type II | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Gastro Esophageal Reflux Disease (GERD) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Other: (PLEASE LIST ANY OTHER MEDICAL HISTORY THAT IS NOT LISTED ABOVE): _____ |

PATIENT'S SURGICAL HISTORY: No Past Surgical History

- | | |
|--|---|
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Cataracts (Right, Left, Both) | <input type="checkbox"/> Kidney Surgery (Donation or Recipient of Kidney) |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> Knee Replacement (Right, Left, Both) |
| <input type="checkbox"/> Foot/Ankle Surgery (Doctor: _____) | <input type="checkbox"/> Pace Maker Implant |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Shoulder Surgery (Right, Left, Both) |
| <input type="checkbox"/> Heart Stent | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Hernia (Right or Left) | <input type="checkbox"/> Wisdom Teeth Extraction |
| <input type="checkbox"/> Hip Replacement (Right, Left, Both) | <input type="checkbox"/> Other (PLEASE LIST ANY OTHER SURGERIES THAT ARE NOT LISTED ABOVE) _____ |

Please Turn Over



DATE: _____

TROY PODIATRIST, P.C.

PATIENT'S FAMILY HISTORY: No Family History

- Acid Reflux Mother / Father / Brother / Sister
- Arthritis Mother / Father / Brother / Sister
- Cancer (If Yes, What Type : _____) Mother / Father / Brother / Sister
- Diabetes (If Yes, What Type : _____) Mother / Father / Brother / Sister
- Gout Mother / Father / Brother / Sister
- Heart Condition (A-Fib or Mitral Valve Prolapse) Mother / Father / Brother / Sister
- Heart Disease Mother / Father / Brother / Sister
- Hepatitis B Mother / Father / Brother / Sister
- Hepatitis C Mother / Father / Brother / Sister
- High Cholesterol Mother / Father / Brother / Sister
- High Blood Pressure Mother / Father / Brother / Sister
- Kidney Problems (Kidney Disease or Kidney Stones) Mother / Father / Brother / Sister
- Liver Disease Mother / Father / Brother / Sister
- Multiple Sclerosis (MS) Mother / Father / Brother / Sister
- Stroke Mother / Father / Brother / Sister
- Thyroid Disorder (Overactive or Underactive) Mother / Father / Brother / Sister
- Tuberculosis Mother / Father / Brother / Sister
- Other (Please list any other Family History that is not already listed): _____

EMERGENCY CONTACT: _____ **PHONE:** _____ - _____ - _____

FAMILY PHYSICIAN: _____ **PHONE:** _____ - _____ - _____

WHO REFERRED YOU TO OUR PRACTICE: _____?

PHARMACY NAME: _____ **LOCATION:** _____ **PHONE:** _____ - _____ - _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Troy Podiatrist, P.C. for all insurance benefits otherwise payable to me for service rendered. I understand that I am financially responsible for all charges, whether or not paid by insurances, and for all services rendered on my behalf or my dependents. I authorize any provider and/or supplier of services in this office to release information required in securing the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ **Date:** _____

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

Troy Podiatrist, P.C. will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other healthcare operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed 'Notice of Privacy Practices' (also known as HIPPA Privacy Laws) to help you better understand our policies in regards to your personal health information. You have the right to review and retain the provided copy of the notice after signing the below acknowledgement. The terms of the notice may change with time and we will always post the current notice at our facilities and have a copy available in the patient waiting room. You may ask us to restrict the use and disclosure of your personal health information. However, we are not agreed upon restrictions. I acknowledge that I have been provided with the Notice of Privacy Practice AND give permissions to access my previous medication history.

Signature of Responsible Party: _____ **Date:** _____

You may give medical and financial information to the following: _____ / _____
NAME / RELATIONSHIP