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

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

_____

_____

PATIENT'S SURGICAL HISTORY: □ No Past Surgical History

□ Adenoidectomy
□ Cataracts (Right, Left, Both)
□ C-Section
□ Foot/Ankle Surgery (Doctor: _____)
□ Gallbladder
□ Heart Stent
□ Hernia (Right or Left)
□ Hip Replacement (Right, Left, Both)
□ Hysterectomy
□ Kidney Surgery (Donation or Recipient of Kidney)
□ Knee Replacement (Right, Left, Both)
□ Pace Maker Implant
□ Shoulder Surgery (Right, Left, Both)
□ Tonsillectomy
□ Wisdom Teeth Extraction
□ 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