Tarheel Podiatry Center, P.A.

Patient's Name _____ Today's Date _____
Date of Birth _____ Age _____Sex_____
Address _____City _____ State___ Zip _____
Phone Number _____Cell Phone _____
*Personal Email Address_____
I agree to receive communications if need be Text_____ Email_____

Patient's Physician's Name _____ Phone Number _____
Address _____ Date of Last Visit_____

Responsible Party's Name _____ SS# XXX-XX-_____(last 4 digits)
Date of Birth_____
Billing address if different from above: _____
Responsible Party's Employer _____Work Phone _____
Contact in Case of Emergency_____
Address _____ Phone Number _____

How did you hear about us? Phone book ___ Friend ___ Dr. ___ Other ____
Due to many changes in insurance policies, I understand it is no longer an easy task for your office to interpret each individual policy. **I understand it is my responsibility to know my individual policy and what is or is not covered by my policy. I also understand that I am responsible for any co-pays, deductibles, and non-covered services that may occur.**

I hereby give permission to Tarheel Podiatry Center, P.A. to examine and perform any diagnostic tests on, and to treat my foot and ankle medically, surgically, and /or orthopedically. I also authorize the release of any medical information necessary to process this claim.

I hereby authorize payments directly to the undersigned physician of the surgical/medical benefits, if any, otherwise payable to me for his/her services.
Signature of Patient or Guardian_____
Today's Date _____

MEDICAL INFORMATION

Describe your foot/ankle problem
_____
_____
Is this problem work related? Y N
Where is the location of your foot/ankle problem _____
How long has it been bothering you? Days _____ Weeks _____ Years _____
How would you describe your pain (Circle all that apply)

DULL ACHING PAIN SHARP SHOOTING PAIN THROB