Tarheel Podiatry Center, P.A.

Patient's Name: _____ Today's Date:_____
Address: _____ City: _____ State:___ Zip: _____
Phone Number: _____ Cell Phone Number: _____
Email address: _____
Date of Birth: __/__/____ Age: ____ Sex: ___

Patient's Physician's Name: _____ Phone Number: _____
Physician's Address: _____ Date of last visit: __/__/____
Responsible Party's Name: _____ Social Security Number:_____
Date of Birth: __/__/____
Billing address if different from above: _____
Responsible Party's Employer: _____ Work Phone: _____

Contact in Case of Emergency: _____
Address: _____ Phone: _____ Work Phone: _____

How did you hear about us? Phonebook ___ Insurance Directory ___ Friend ___ Doctor___
Other _____

Due to many changes in insurance policies, I understand that it is no longer an easy task for your office to interpret each individual policy. I understand that 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.

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

Have you had any previous treatment? _____
Is this a work related injury? _____
Do you smoke? _____ If so, how much per day? _____ Alcohol consumption: ____
Chemical use? _____
Height: _____ Weight: _____ Shoe size: ___

Please list all surgeries anywhere on body: _____
_____

Please circle if you have any of the following:

AIDS/HIV	Ear problems	Phlebitis
Allergies to Anesthetics	Eye problems	Psychiatric care
Arthritis	Diabetes	Rash
Back problems	Gout	Breathing problems
Bleeding disorders	Headaches	Sinus problems
Blood clots	Heart disease / attack	Special diet
Cancer	Hepatitis	Stroke
Chest pain	High blood pressure	Thyroid DS
Drug use / dependency	Kidney problems	Tuberculosis
Diarrhea	Liver disease	Ulcers
		Varicose veins

Family medical history: Mom: _____ Dad: _____

Medications: _____
_____
_____
_____

Allergies: _____

Signature of patient
or guardian: _____
Date: _____