WELCOME TO ORLAND PODIATRY CENTER

Patient # _____

PATIENT INFORMATION

Date _____

Patient Name _____
Last Name

_____ _____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

SS# _____

E-mail _____

Sex ☐ M ☐ F Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Divorced

Patient Employer / School _____

Employer / School Address _____

_____

Employer / School Phone (____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

PHONE NUMBERS

Home Phone (____) _____

Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Phone (____) _____

INSURANCE

Who is responsible for this account? _____

Relationship to patient _____

Insurance Co. _____

ID# _____

Birthdate _____ SS# _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Insurance Co. _____

ID# _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that that I have insurance coverage and assign directly to Dr. Bies all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits be made either to me or on my behalf to Dr. Bies for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits for related services.

_____ _____
Signature of Beneficiary, Guardian or Personal Representative Date

_____
Please print name of Beneficiary, Guardian or Personal Representative

PRIVACY POLICY

I acknowledge that i have been given the HIPPA agreement for my review. I understand that if I have any further questions I will contact the Privacy Practices officer in Dr. Bies' office.

_____ _____
Signature of Beneficiary, Guardian or Personal Representative Date

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

_____

Have you ever been to a Podiatrist before?

☐ Yes ☐ No

If yes, please list.

Name _____

Last visit _____

Is there any personal or family history of diabetes?

☐ Yes ☐ No

Your occupation _____

Tobacco use: None Light Moderate High

Alcohol use: None Light Moderate High

Athletic activities in which you participate. (Please list and indicate frequency.)

_____

_____

_____

Please indicate which foot problems you now have or have had in the past.

- ☐ Ankle Pain
- ☐ Athlete's Foot
- ☐ Bunions
- ☐ Corns and Calluses
- ☐ Cramps or Numbness
- ☐ Flat Feet
- ☐ Foot or Leg Cramps
- ☐ Heel Pain
- ☐ Ingrown Toenails
- ☐ Plantar Warts
- ☐ Swelling in Ankles or Feet
- ☐ Tired Feet

Patient # _____

MEDICAL HISTORY

Please indicate if you have had any of the following:

- ☐ AIDS / HIV
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ Anemia
- ☐ Anigina
- ☐ Arthritis
- ☐ Artificial Heart Valves or Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Chemical Dependancy
- ☐ Chest Pain
- ☐ Chronic Diarrhea
- ☐ Circulatory Problems
- ☐ Diabetes
- ☐ Ear Problems
- ☐ Epilepsy
- ☐ Eye Problems
- ☐ Fainting
- ☐ Foot or Leg Cramps
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hepatitis or Jaundice
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Neuropathy
- ☐ Phlebitis
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Rash
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Special Diet
- ☐ Stroke
- ☐ Swelling in Ankles, Feet
- ☐ Swollen Neck Glands
- ☐ Tired Feet
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Weight Loss, unexplained

Past Surgeries _____

_____

Hospitilization other than the surgeries listed _____

_____

Last X-Ray _____ Last Blood Test _____ Last Physical _____

Family Physician _____ Last visit date _____

Are you now or have you been under any doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

MEDICATIONS

Include perscriptions, over the counter medications and vitamins (or attach list)

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) (____) _____

Do you take oral contraceptives? ☐ Yes ☐ No

FAMILY HISTORY

Do any of your family members have any of the following conditions?
(Indicate which relative)

- ☐ Diabetes _____
- ☐ Cancer _____
- ☐ Heart Disease _____
- ☐ Hepatitis _____
- ☐ HIV (AIDS) _____
- ☐ Other _____

ALLERGIES

- ☐ Adhesive /Tape
- ☐ Anticoagulant Therapy
- ☐ Local Anesthetics
- ☐ Codeine
- ☐ Demerol
- ☐ Iodine
- ☐ Aspirin
- ☐ Novocaine
- ☐ Penicillin
- ☐ Seafoods
- ☐ Sulfa

Other _____

_____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of Beneficiary, Guardian or Personal Representative — Date

_____ _____

Please print name of Beneficiary, Guardian or Personal Representative — Relationship to Beneficiary