PATIENT INFORMATION

Pharmacy: ______________________

Patient's Name: ____

DOB:_____/______/______ Social Security #: ______ - _____- ______ Marital Status: M S W D

Address: ____

(Street) (City, State) (Zip)

Home Phone (_____)______-______ Cell Phone (_____)_____-______ Work Phone (___)____-____

Employer:____/email_____________________________

Name of Spouse, Parent, or Significant Other_______________________ Phone/Cell #_____________

Referring Physician: _________________________________ Family Doctor: _____________________

Emergency Contact:_____________________________ Phone/Cell #:____________________________

(Name/Relationship)

INSURANCE INFORMATION

Primary Insurance Co.:____________________________________ Policy #: _______________________

Name of Insured: __________________ DOB: ______________________ SS#: _____________________

Secondary Insurance Co.:__________________________________ Policy #: ______________________

Name of Insured:__________________ DOB:_______________________SS#:_____________________

I understand that I am financially responsible for **ALL** charges to me, including co-payments, co-insurance, out-of-pocket and deductibles. I authorize payment of medical benefits and I assign benefits payable to William A. Harr, D.P.M., P.A. for professional services rendered. I understand that I will receive statements reflecting my account balance and that the FINAL PAYMENT of this account is my responsibility. Furthermore, should I default on my payment for services rendered I agree to pay all collection costs including reasonable attorney's fees. **PLEASE BE ADVISED THAT YOUR INSURANCE HAS BEEN VERIFIED BUT IS NOT A GUARANTEE OF PAYMENT.**

This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned.

Signed:____ Date: ____/_____/_____

HIPAA RELEASE

I authorize William A. Harr, D.P.M., P.A. to discuss my health care with, and/or leave a detailed message on my answering machine/voicemail:

____ _________________________

(Name) (Relationship)

____ _________________________

(Name) (Relationship)

Signed:____ Date: ____/_____/______

PATIENT HISTORY

*Please fill out all forms to the best of your ability. The staff will go over the form and answer and questions you may have.

Name: ____ Date: _____/_____/______

Age: ______ Height:_________ Weight:___________ Shoe Size:__________

1) What is the main problem with your feet or ankles?
 ____

2) When did you first notice the condition?
 ____

3) Is this an injury? _____ Yes _______ No If Yes, when did it occur? ____________________

 If Yes, did it happen at work? _____ Yes ______ No
 Are you claiming Workman's Comp? ______ Yes _______ No

4) Check all of the following that apply:

 Type of Pain ____ Burning ___ Tingling ____ Sharp _____ Dull Ache _____ Throbbing
 ____ Shooting ___Stabbing ____ Numbness

When Painful ___ Upon Standing ___ During Walking ___ After Walking
___ During Sports ___ Worse with Activity ___ Better as Activity Continues
___ Worse when standing ___ With Shoes ___ Without Shoes
___ AM ___ PM ____ Lying in bed ___ Always

5) How painful is your condition? 0 = "no pain" and 10 = "the worst pain you have ever experienced, please circle your pain level:

0 1 2 3 4 5 6 7 8 9 10

6) How has this affected your daily routine and what activities does this keep you from performing?
____
____
____
____

7) Have you had foot care before? ____ Yes ____ No
If so, by whom and when? : ____

MEDICATIONS:

Pharmacy: ______________________________ Number: _____________________

Medication	Dosage	How Often Taken?	What is it taken for?

ALLERGIES:

□ None □ Other ____

□ Penicillin □ Sulfa □Iodine □Aspirin □Anesthetics □Latex □Codeine

□Demerol □Darvocet □Cortisone □Environmental □Food

Type of reactions: ____

MEDICAL HISTORY:

*Please circle any of the following conditions that you have or have had in the past.

Diabetes Fibromyalgia Tumors Epilepsy Nerve Conditions Heart Problems

Arthritis Gout Asthma/COPD Glaucoma Stomach Ulcers Skin Disorders

Tuberculosis Anemia Bursitis Aids (HIV) Lung Disease Kidney Problems Sickle Cell

Stroke Hepatitis Osteoporosis Bleeding Problems Colitis/Crohn's Mental Disorders

Poor Circulation High Blood Pressure Joint Implants Thyroid Disease High Cholesterol

Rheumatic Fever Heart Burn/Reflux Sexually Transmitted Diseases

Cancer; Type_________________ Other:_________________________________

Diabetes; What is the name, phone number, and address of the doctor treating you for diabetes?

____

When was your last visit? ____/_____/_____ What is your average blood sugar reading? _____________

Are you pregnant?____Yes _____No If yes, how many months? ________

SURGICAL HISTORY

Procedure	Date	Complications

Have you ever been hospitalized other than for surgery? ____ Yes ____ No

If yes, Explain:

____

____

____

FAMILY HISTORY

*Please check all that apply

	FATHER	MOTHER	BROTHER	SISTER
Diabetes				
Heart Disease				
High Blood Pressure				
Arthritis				
Gout				
Thyroid				
Cancer (what type)				
Other				

SOCIAL HISTORY

Date of last physical exam: ___/___/____ Occupation: ______________________________

Activities: ____

Level of activity: ____Occasional ____ Weekly ____Competitive ____Professional

Do you smoke tobacco? ____ Yes _____ No

If yes: # packs per day? ____ # cigarettes per day?___ # years smoking?_____

If no: Did you ever smoke? ____ Yes _____ No

If Yes: How long ago did you stop smoking? __________________

Do you drink alcohol? ____ Yes _____ No

If yes: How much? ___1 per week ____1-2 per week ____ 1-2 per day ___ more than 3 per day

Recreational drug use:

Any type of drug use is a personal choice and will in no way adversely effect your relationship with the doctor. However, many drugs can interact with other medications and treatments with potential life threatening effects. Therefore, it is extremely important that you answer honestly. Your response will be held in the most strict patient-doctor confidentiality.

Answer: _____ Yes _____ No
If yes: What substance and how often used?____
____

REVIEW OF SYSTEMS

*If you are experiencing any of the following please circle

Head: Chronic headaches Concussions Dizziness Loss of consciousness

Eyes: Glasses Contacts Double vision Blurred vision Blindness Cataracts

Ears: Decreased or loss of hearing Ringing in ears Chronic earaches

Nose: Drainage Infections Blockage Bleeding Sinusitis

Throat: Chronic tonsillitis Laryngitis Difficulty swallowing Loss of speech

Cardiovascular: Chest pain Shortness of breath Palpitations Murmurs

Heart valve disease Anemia Leg Cramps

Respiratory: Bronchitis Pneumonia Difficulty breathing Wheezing Chronic cough

Gastrointestinal: Nausea Vomiting Diarrhea Constipation Weight gain or loss

Blood in stool Black stool Excessive gas Loss of appetite

Genitourinary: Chronic kidney or bladder infections Problems voiding Pain with urination

Dark or bloody urine Discharge from penis or vagina

Gynecologic: Painful or irregular periods Absence of periods (not in menopause)

Vaginal discharge

Other: ____

Do your legs swell? Yes No

Do you have back problems or have had a back injury?

Yes I am not experiencing any of the above symptoms.

NOTICE OF PRIVACY PRACTICES (HIPAA REGULATIONS)

You were provided with a document entitled "Notice of Privacy Practices." It is required by governmental regulations that all medical facilities provide you with this notice. Please check the box to acknowledge that you have read (or had the opportunity to read if you chose) and understand the notice. This is a copy of the notice that is yours to keep. If you do not want the copy, simply return it to the receptionist with your other materials.

CONSENT:

I certify that the information above is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures, including therapeutic and diagnostic injections, as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature: ____