

# Patient Information

**PLEASE COMPLETE ALL FORMS**

## Patient Information

Last Name:		
First Name:	Middle Initial:	
Maiden Name:		
Address:		
City:	State:	Zip:
Primary Physician:		
Referred by:	<input type="checkbox"/> Advertisement	<input type="checkbox"/> Friend
<input type="checkbox"/> Health Fair	<input type="checkbox"/> Letter	<input type="checkbox"/> Yellow Pages
Referring Physician Name:	<input type="checkbox"/> Internet	
Your Email:		
Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Date Of Birth:		
Home Phone:		
Cell Phone:		
Social Security #:		
Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
If Student check this box:	<input type="checkbox"/>	
Pharmacy Name:		
Pharmacy Address:		

## Patient Employer Information

Patient's Employer:		
Work Phone:		
Extention:		
Employer's Address:		
City:	State:	Zip:

## Primary Insurance Information

Primary Insurance Company:	
Relation to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Insured Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Insureds Name:	
Insured Place of Employment:	
Insured's Home Address:	
Insureds Date Of Birth:	
I.D.#	Group #:
Telephone # if available:	

## Secondary Insurance Information

Secondary Insurance Company:	
Insureds Name:	
Insured Place of Employment:	
I.D. #:	
Group:	Insured's DOB
Insured Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Insured Telephone # if available:	

(PLEASE CHECK ONE)

Workman's Comp or  Auto Accident

Insurance Name:	
Date of Injury:	
Claim Number:	
Claim Adjustor's Name:	
Phone:	Fax:

# Medical History

**WHAT** is your foot problem? \_\_\_\_\_

**WHEN AND HOW** did it start? \_\_\_\_\_

Describe **ANY** previous foot treatment & by **WHOM** \_\_\_\_\_

Do you have or have you had any of the following: **MUST** **X** "Yes" or "No" to ALL questions.

	Yes	No		Yes	No		Yes	No
Abnormal heart condition			Tingling in Feet			Stomach disorder		
Heart murmur			Burning in Feet			Chronic Fevers		
Abnormal blood pressure			Decreased Sensation			Shortness of Breath		
Abnormal bleeding from a cut			Radiating Pain into the Feet			Cramps in Legs when Walking		
Diabetes Type 1 2 (please circle)			Increased Thirst			Cramps in Legs when Sleeping		
Arthritis Type _____			Increased Urination			Weakness of Legs		
Kidney Disease			Difficulty in healing			Jaundice		
High Cholesterol			Joint Aches or Pains			Thick/Discolored Toe Nails		
Blood Clots (phlebitis)			Morning Stiffness			Thick/Discolored Fingernails		
Asthma			Pain in Feet in the Morning when Rising			Dry Skin		
Seasonal Allergies			Swelling of Joints			Skin Rash		
Hepatitis or liver disease			Limited Motion of Joints			Skin Cracking		
Hypothyroidism			Chronic Low Back Pain			Other Illnesses		
Chest Pain			Decreased Appetite					

**Do you have :** Yes No

	Yes	No		Yes	No
Fatigue			<input type="checkbox"/> Buttocks <input type="checkbox"/> Thigh <input type="checkbox"/> Calf <input type="checkbox"/> Feet	Poor Healing of Wounds of Legs or Feet?	
Aching			<input type="checkbox"/> Buttocks <input type="checkbox"/> Thigh <input type="checkbox"/> Calf <input type="checkbox"/> Feet	Pain at Rest of Legs or Feet?	
Numbness			<input type="checkbox"/> Buttocks <input type="checkbox"/> Thigh <input type="checkbox"/> Calf <input type="checkbox"/> Feet	Pain Reduced When You Stand?	
Pain			<input type="checkbox"/> Buttocks <input type="checkbox"/> Thigh <input type="checkbox"/> Calf <input type="checkbox"/> Feet		

Are you presently taking **ANY** medications?  Yes  No If yes, **Name** of medications and **Why** you are taking it: \_\_\_\_\_

**Do you have any allergies to:**

	Yes	No		Yes	No
Penicillin			Local anesthetics (Novacaine)		
Aspirin			Codeine		
Adhesive tape			Other Allergies		
<b>REACTION:</b>					

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

# Medical History Continued

Have **YOU** ever had surgery?  Yes  No If yes, list nature and year of surgery: \_\_\_\_\_

Have **YOU** ever been hospitalized?  Yes  No If yes, list nature and year of hospitalization: \_\_\_\_\_

## About Your Medical History Only

Have you ever had any broken bones in your foot or ankle?  Yes  No

Do you smoke?  Yes  No years smoking \_\_\_\_\_ packs per day \_\_\_\_\_

Do you drink alcohol?  Yes  No how much per week \_\_\_\_\_

## About Your Family's Medical History Only

Do you have a family history of any of the following?

Diabetes:  Yes  No  Mother  Father

Heart Disease:  Yes  No  Mother  Father

Blood Clots:  Yes  No  Mother  Father

Bleeding Problem:  Yes  No  Mother  Father

Stroke:  Yes  No  Mother  Father

Arthritis:  Yes  No  Mother  Father

Type of Arthritis: \_\_\_\_\_

Cancer:  Yes  No  Mother  Father

Type of Cancer: \_\_\_\_\_

### Person to contact in an emergency:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Relationship: \_\_\_\_\_

### SIGNATURE AUTHORIZATION

I authorize payment of medical benefits to Doctor Fein and Tauber.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I authorize the release of any medical information necessary to process this claim.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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Fax: 203-744-2811 • www.BethelPodiatry.com

**ACKNOWLEDGEMENT OF RECEIPT**

**OF**

**NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Authorized Rep. (if applicable)

\_\_\_\_\_  
Signature

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Due to the HIPPA Privacy Act I am aware that no one other than my Insurance Company or my Medical Provider is allowed to have access to my medical records or any information pertaining to my care. No family members unless indicated below, will be allowed to access this information.

Therefore I also give my permission for the following person/people to have access to my medical information.

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Name (please print)