FAYETTE PODIATRY

631 A National Pike, Brownsville, PA 15417
Phone: 724-785-8060 Fax: 724-785-6217

DATE: ________________ Marital Status: S- M- W- D Race: White – African Amer. - Asian- Latino- Other_____

Name:____ Social Sec #______-_____-_______
(Last) (First) Middle Initial)

Address:____ City________________ State:_____ Zip:________

Home Phone #:_____-_____-______ Cell Phone #:______-______-______ Work Phone #: ___-____-____

Date of Birth: _____ /_____/______ Age:_______ Email Address:___________________________________
(month) (day) (year)

HEIGHT : ___________ WEIGHT:___________ Shoe Size:____________ Gender: Male - F emale

Employer:____________________ _____ Employer Phone_________________ Occupation____________________

Employer Address:____

Emergency Contact _________________________________ Emergency Contact Phone__________________

Pharmacy Name ____ Pharmacy Number___________________________

Primary Care Physician:_______________________________ PCP Phone#________________________________

When did you last see your PCP?______________________________ Referred By:______________________________

Please List your CURRENT MEDICATIONS: ____

____

What is your CURRENT Foot Problem (Please specify which foot, toe, area) _______________________________________

____

Are you in good general health? ( ) Yes ( ) No. If No please explain:____

Are your feet tired at the end of the day? ( )Yes ( )No Do you have lower back pain? ( ) Yes ( ) No
Have you ever broken your foot/ankle? ( ) Yes ( ) No Have you previously had foot/ankle surgery? ( )Yes ( ) No
Do you use tobacco products ? ( )Yes ( ) No If yes, how much daily ? ___________________
Do you drink Alcohol? ( )Yes ( )No If yes, how much daily? _________________________
Do you consume illegeal/recreational drugs? ( )Yes ( ) No If yes, which drugs/how often do you use?______________
Any exposure to Fumes/Solvents/Dust/Air-Borne Particles/Noise: ( ) Yes ( )No

Please check (√) if you have had any of the following conditions:

( ) Arthritis/Rheumatism	( ) Cramps/Numbness in feet/legs	( ) Heart trouble	( ) Seizures
( ) Asthma	( ) Diabetes	( ) High Blood Pressure	( ) Stroke
( ) Bleeding Disorder	( ) Eye trouble	( ) Kidney Trouble	( ) Swelling of feet or ankles
( ) Cancer	( ) Hereditary Diseases	( ) Liver trouble	( ) Varicose Veins

Please Check (√) if you are allergic to any of the following :
( ) Anesthetics ( ) Food ( ) Latex ( ) Materials

( ) Medications ( ) Novocain ( ) Penicillin's ( ) Tape

( ) Other
Please specifiy:____

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continued onto the next page
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Family Medical History

	Age		Medical Conditions	If deceased, cause of death
Father	____		_____	_____
			_____	
Mother	____		_____	_____
			_____	
Siblings	____	m/f	_____	_____
	____	m/f	_____	_____
	____	m/f	_____	_____
	____	m/f	_____	_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED WITH A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAVE HAD THE OPPORTUNITY TO READ IF I CHOOSE) AND UNDERSTAND THE NOTICE

_____ _____ _____

PRINT NAME DATE OF RECEIPT PARENT OR AUTHORIZED PERSONAL REPRESENTATIVE

_____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform my doctor.

I will authorize my insurance company to pay the doctor or medical group all insurance benefits payable to me for services rendered.
I authorize the user of this signature on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits**.**

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date_____

PAYMENT IS DUE AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

SIGNATURE ON FILE: In order to submit a claim for payment to us or for reimbursement to you for services covered under your policy. We must have your authorization to release medical information to your insurance carrier.

I hereby authorize a physician of Fayette Podiatry Associates to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by FAYETTE PODIATRY ASSOCIATES. And direct my insurance carrier or its intermediaries to issue payment checks directly to Fayette Podiatry Associates for services I did not pay for.

I understand that I am financially responsible to Fayette Podiatry Associates for any balances not covered by my insurance carrier. ____ (please initial)

A copy of this signature is as valid as the original. ____ (**please initial**)

_____ _____

Patient Signature Date of Signature