PATIENT INFORMATION AND HISTORY

PATIENT INFORMATION

Patient Name: _____

Date: _____SS#:_____

Permanent Address:_____

City/State/Zip:_____

Local Address:_____

City/State/Zip:_____

Date of Birth: _____Please Circle: Male or Female

_____Married _____Single _____Divorced _____Widow

Employer:_____

Work phone # :_____

Spouse's Name: _____

E-Mail:_____

How were you referred to our office? (Ex: dr., ins, patient, sign, phone book)

PHONE NUMBERS

Patient Home #: _____ Cell/Alternate :_____

IN CASE OF EMERGENCY, CONTACT:
Name _____
Relationship to patient _____
Home # _____ WK #_____

PERSON RESPONSIBLE FOR THIS ACCOUNT

(IF DIFFERENT FROM PATIENT)
Name: _____
Relationship to patient: _____
Address _____
City/State/Zip _____
Home #_____ WK#_____

INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Insured: _____

Date of birth:_____ Relationship to patient_____

Insurance Name _____

Insured's ID #_____ Group/Policy #_____

Insured's Employer _____

Secondary Insurance (If applicable)

Name of Insured: _____

Date of birth_____ Relationship to patient_____

Insurance Name _____

Insured's ID#_____ Group #_____

Insured's Employer_____

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____
(NAME OF INSURANCE COMPANY)
and assign directly to Dr. Lori Finn all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for costs not covered or reimbursed by third party payors. I authorize the use of this signature on all insurance submissions and certify that the information provided here is true and correct.

Dr. Lori Finn 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 relates services. The consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE AUTHORIZATION

I authorize the Social Security Administration to disclose information regarding my Medicare coverage, including but not limited to, verification or my Medicare number, effective dates, and type of coverage.

The understand certifies that he/she has read the foregoing and is the patient, or is duly authorized by that patient as patient's general agent to execute the above and accept its terms. It is further understood that this release remains in effect for one (1) year unless otherwise revoked.

_____
SIGNATURE OF PATIENT/GUARDIAN/PERSONAL REP.

_____
PLEASE PRINT NAME OF ABOVE SIGNATURE

_____
DATE RELATIONSHIP TO PATIENT

Patient Name: _____

My foot problem is: _____

_____How long?_____

Prior or self-treatment for this problem: _____

_____

MEDICAL HISTORY Circle any condition YOU currently have or have had:			
Anemia	Ear/hearing problem	HIV (AIDS)	Nerve Pain
Asthma	Epilepsy	Kidney/Urine problems	Phlebitis
Arthritis	Fever	Leg Cramps	Poor Vision/Eye problems
Allergies (seasonal)	Gout	Liver problem	Circulation Problems
Artificial Joints	Heart problems	Low Back problems	Stomach Ulcers/ problems
Bleeder	Heart Valve Implant	Mental/Emotional problems	Stroke
Chest pains	Hepatitis	Muscle Weakness	Tuberculosis
Cancer	High Blood Pressure	Numbness	Unequal Leg Length
Diabetes YES NO Insulin? YES NO	Dementia	Rashes	Varicose Veins
If DIABETIC, doctor treating diabetes: *Dr. Name*_____ *Phone #*_____ *Last date seen*_____			

MEDICATIONS List any prescriptions, over-the-counter, and vitamins		ALLERGIES List any allergies (ex: penicillin, tape, etc..)	

ADDITIONAL HISTORY		
Do you smoke? Yes No	If yes, how much: How long:	List any surgeries/hospitalizations (include foot surgery)
Do you drink alcohol? Yes No	If yes, amount:	
What is your Height:_____ Weight:_____ Shoe size:_____		
Name of Family Doctor:		
Dr. phone number:	Last date seen:	

Circle YES or NO to report your **FAMILY HISTORY** (blood relatives)			
	RELATIVE:		**RELATIVE:**
Diabetes YES NO		Flat Feet YES NO	
Cancer YES NO		Tuberculosis YES NO	
Bleeder YES NO		High Blood Pressure YES NO	
Hepatitis YES NO		HIV (AIDS) YES NO	
Bunions YES NO		Heart Problem/Stroke YES NO	
Hammertoes YES NO		Circulation Problem Leg/Feet YES NO	

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 Patient, Parent, Guardian, or Personal Representative Date

_____

Please Print Name

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

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

_____
Name (please print name)

_____
Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature