Palm Tree Podiatry - New Patient Form - Please Print

Full name_____

DOB:_____ Sex:_____

Address_____ City_____ State____ Zip_____

Contact Number_____ Email_____

Appointment reminder preference (circle one): Phone Call Text No Reminders

Marital status (circle one): Single, Married, Widowed, Partnered Race_____

Emergency Contact_____ Relation_____ Phone_____

Primary Care Physician_____Phone_____

Pharmacy (name & address or road)_____

How did you hear about our practice? Internet / Friend / Family / Insurance / Doctor Referral

Referred by: _____ Other:_____

Assignment of Benefits & Authorization for Release of Information If I am entitled to benefits under Medicare, Medicaid, or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me), in consideration for services provided to me by Palm Tree Podiatry PLLC, I assign, transfer and convey the benefits payable under such program, policy or plan for services rendered by to me and I authorize the payment of benefits to be applied to my bill. I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay any charges not paid under this assignment, including any coinsurance amounts, deductibles, durable medical equipment I have received and any charges for services rendered deemed to be non-covered, not pre-certified, or not preauthorized by my insurance plan. _____(initial)

I give my consent for examination and treatment by Palm Tree Podiatry and to the best of my knowledge, I have answered the questions on this form as accurately and truthfully as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and the staff of any changes to my medical status.

Responsible party signature:(insured)_____ Date:_____

Responsible party signature:(self pay)_____ Date:_____

If not signed by patient please indicate relationship to the patient:

Relationship_____ Date: _____

Visit Information: What is the reason for your visit today? _____

How long has this bothered you?_____

What treatments have you tried & have they been effective _____

_____

Medical History:

Have you had any past problems with your feet or ankles? Yes No

If yes, please describe: _____

Do you have any food, drug, or latex allergy? Yes No

If yes, please specify (allergy & reaction):_____

Please indicate if you have, or had in the past, any of the following:

__Alcoholism __Blood Disorders __Gout __Liver disease __Sleep Apnea __Seasonal Allergies __Cancer
__Asthma __Edema __Kidney Disease __Vascular disease __High Blood Pressure __Heart Disease
__Leg or Foot Ulcers __Organ Transplant __Osteoporosis __Pacemaker __Polio __Epilepsy/Seizures
__Stroke __Rheumatoid Arthritis __Substance Abuse __Thyroid Problems __Varicose Veins __Dialysis
__Diabetes __Deep Vein Thrombosis __High Cholesterol __Fibromyalgia __Headaches __Aids/HIV
__None of the above __Other Specify _____

Do you have artificial joints? __Yes __No
If yes, please describe:_____ Date of surgery:_____
Have you had any other surgical procedures anywhere else on your body? __Yes __No
If yes, please describe:_____ Date of surgery:_____
Are you pregnant? __Yes __No Are you nursing? __Yes __No
Are you disabled/on disability? __Yes __No Do you have an artificial heart valve? __Yes __No
Current Medications: _____

Family History:

Did/does any family member have: **(Mother = M/Father = F/Both Parents = B/Sibling = S/Grandparent = G)**
__Alcoholism __Blood Disorders __Gout __Liver disease __Sleep Apnea __Seasonal Allergies __Cancer
__Asthma __Edema __Kidney Disease __Vascular disease __High Blood Pressure __Heart Disease
__Leg or Foot Ulcers __Organ Transplant __Osteoporosis __Pacemaker __Polio __Epilepsy/Seizures
__Stroke __Rheumatoid Arthritis __Substance Abuse __Thyroid Problems __Varicose Veins __Dialysis
__Diabetes __Deep Vein Thrombosis __High Cholesterol __Fibromyalgia __Headaches __Aids/HIV
__None of the above __Other Specify _____

Social History:

Do you currently smoke tobacco? __Yes __No If no, have you ever smoked tobacco? __Yes __No
If yes, how many cigs/packs per day?_____How many years did you smoke?_____
Do you consume alcohol? __Yes __No If yes, how many drinks per week?_____
Any other drug use? _____
Do you have housing? __Yes __No Do you have food security? __Yes __No
What physical activities do you currently participate in? _____
How many minutes or hours at a time?_____ How many days per week?_____
Do you have any of the following?
__Flat Feet __High Arch __Toe pain/numbness __Knee Pain __Hip Pain __Lower back pain __Ankle pain
__Tired or achy legs __Heel pain __Calluses on your feet/toes __Pain at the ball of foot __None of these

Review of Systems:

Do you have any of the following (circle all that apply):

(CO): fever / nausea / chills / recent increase in weight / recent decrease in weight
(CA): chest pain / palpitations / leg swelling / leg pain when walking
(RE): shortness of breath / pain upon breathing / wheezing / cough
(NE): recurring headaches / seizures / tingling to extremities / weakness to extremities
(GA): heartburn / stomach ulcers / change in appetite / trouble swallowing
(IN): rash / dry skin / itchy skin / nail abnormalities
(MU): joint pain / limited joint motion / joint swelling / back pain
(IM): recurring infections