



Palm Tree Podiatry - New Patient Form - Please Print

Full Name _____ HT: _____ WT: _____ Diabetic: Y/N
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 shelter? ☐ Yes ☐ No

Do you have enough food to eat regularly? ☐ 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