

ELITE PODIATRY

102 Essex ct. Ste D Madison, Al 35758
Phone: 256-850-0640 Fax: 256-850-4863

WELCOME TO OUR OFFICE!

NEW PATIENT INTAKE FORM

Name : _____ Gender _____ M _____ F

Date of Birth _____ Age _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip _____

Home Phone # _____ Work Phone #: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____ Cell Phone: _____

E-mail Address: _____ Primary Spoken Language _____

Primary Care Physician: _____ Referred by: _____

Cardiologist: _____ Endocrinologist: _____

Nephrologist: _____ Rheumatologist: _____

Please describe your foot/ankle problem (include date of injury if applicable)

How long has the problem been present? _____

Have you had any treatment or taken anything for it? _____

Have you seen someone for this already? ___No ___Yes Whom? _____

Have you had any prior foot/ankle problems? If yes, please describe: ___No ___Yes

ALLERGIES

Please check all allergies:

_____ Medications: _____

_____ Foods: _____

_____ Tapes or Topical Skin Sensitivity _____ Other: _____

What types of reactions have you experienced?

MEDICATIONS

Please list all medications and the dosages:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

PERSONAL MEDICAL HISTORY

***** Check those that apply to you now or have applied to you in the past *****

<input type="checkbox"/>	Frequent Headache/Migraines	<input type="checkbox"/>	Anemia/Blood Disorders
<input type="checkbox"/>	Liver Disorder	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Drug/Alcohol Abuse
<input type="checkbox"/>	Dialysis M W F or T TH SA	<input type="checkbox"/>	Epilepsy or Seizures
<input type="checkbox"/>	Diabetes Average Blood Sugar _____	<input type="checkbox"/>	Prolonged Bleeding Time
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Stomach/ Ulcer Disorder
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Thyroid/Parathyroid Disease
<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Chest Pain on Mild Exertion	<input type="checkbox"/>	Psychiatric Treatment
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Emotional Problems/Tension
<input type="checkbox"/>	BLOOD CLOTS	<input type="checkbox"/>	Asthma/ Hay Fever / Shortness of Breath
<input type="checkbox"/>	Tumor/Abnormal Growth/ Cancer	<input type="checkbox"/>	Sexually Transmitted Disease
<input type="checkbox"/>	Ear, Nose, Throat Disorder	<input type="checkbox"/>	Prostate Disorder
<input type="checkbox"/>	Hepatitis/ HIV	<input type="checkbox"/>	Other

PATIENT INFORMATION

Do you smoke currently? _____ Yes _____ No How many packs per day? _____ For how many years? _____

Have you smoked previously? _____ Yes _____ No When did you quit? _____

Number of caffeine drinks per day? _____ Amount of alcohol consumed per week _____

For women only: Are you pregnant? _____ How many months? _____

Please complete the following:

Height: _____ Weight: _____ Shoe size: _____ Occupation: _____

Is there any other information you would like us to be aware of: _____ No _____ Yes

Please describe: _____

MEDICAL CONDITIONS

Diabetes	High Blood Pressure	Heart Disease	Heart Murmur	Heart Valve	Siezuers
Asthma	Rheumatic Fever	Hepatitis	Stroke	Gout	Anemia
Stomach Ulcers	Liver Disease	Circulation	Cancer	Infections	HIV
Nerve Problems	Thyroid	Kidney Disease	Bleeding	Scarring	Fever
Tuberculosis	Hormones	Arthritis	Chills	Seizures	

Muscular/Skeletal

Weakness of muscles	Joint Pain	Joint Redness	Joint Swelling
Morning Stiffness	Leg Cramps	Back Pain	
Muscle Tenderness	Neck Pain	Stiffness	Difficulty with walking

Neurological

Burning in feet Tingling in feet or toes Numbness Tremors

Psychiatric: Addictions Attempted Suicide Depression Memory loss Panic Attacks
I hereby authorize direct payment of surgical and medical benefits on my behalf to the provider of these services that I would otherwise be payable to me if I did not make this assignment. I understand that I am personally responsible to the physician for charges not covered by my insurance agreement. I also understand that if my account becomes delinquent, I will be responsible for any costs of collection of my account, including collection fees and attorney costs. A \$5.00 per month re-invoicing fee may apply to all accounts 60 days past due. I permit a copy of this assignment to be used in lace of the original for purpose of billing.

The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital generated. Also, I herby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition, to use x-ray examination, or photographs as necessary.

I give Elite Podiatry Inc. permission to obtain and release medical information to insurance companies and referring physicians. I have read the following and understand and agree to Elite Podiatry Inc. office policy.

Date

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

** If not patient, relationship to patient

___ Parent ___ Power of attorney ___ Legal Guardian ___ Other