TODAY'S DATE: ___/____/____

LAWRENCE PODIATRY CENTER

PATIENT INFORMATION FORM

(PLEASE PRINT)

PATIENT NAME: _____ _____ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

PREFERRED PHONE #: (____) ____-_____ CELL PHONE #: (____) ____-_____

E-MAIL: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

PRIMARY CARE DOCTOR: _____

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____
DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

WHOM MAY WE THANK FOR REFERRING YOU TO US?_____

WE ARE OBLIGED BY FEDERAL GUIDELINES TO ASK THE FOLLOWING QUESTIONS. ☐ I DECLINE TO ANSWER
ETHNICITY: ☐ HISPANIC ☐ NON-HISPANIC PREFERRED LANGUAGE: _____
RACE: ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER
☐ WHITE

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

SECONDARY INSURANCE COMPANY NAME: _____

INSURED NAME: _____ **DATE OF BIRTH** _____ EMPLOYER _____

YOUR MEDICAL HISTORY

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

PREFERRED PHARMACY: _____

ALLERGIES:

☐ PLEASE MARK IF NO ALLERGIES

_____

_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS): ☐ PLEASE MARK IF NO MEDICATIONS CURRENTLY TAKEN

NAME	DOSE	NAME	DOSE
_____		_____	
_____		_____	
_____		_____	
_____		_____	

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	GOUT	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	HEART ATTACK	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART DISEASE/FAILURE	Y	N	PVD OR PAD	Y	N
ASTHMA	Y	N	HEPATITIS	Y	N	POLIO	Y	N
AUTOIMMUNE DISEASE	Y	N	HIGH CHOLESTEROL	Y	N	RHEUMATIC FEVER	Y	N
BACK TROUBLE	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
CANCER	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
DIABETES	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
EMPHYSEMA	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
FIBROMYALGIA	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:			MULTIPLE SCLEROSIS	Y	N			

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____		_____	
_____		_____	
_____		_____	

IMMEDIATE FAMILY HISTORY

	MOTHER	FATHER	CHILD	SIBLING	OTHER
CORONARY ARTERY DISEASE	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐
RHEUMATOID ARTHRITIS	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐
OTHER _____	☐	☐	☐	☐	☐

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

SMOKING: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ LIGHT SMOKER ☐ HEAVY SMOKER

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYED: ☐ EMPLOYED ☐ NOT EMPLOYED OUTSIDE HOME ☐ RETIRED ☐ DISABLED ☐ STUDENT
EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____ ☐ PET(S)–WHAT KIND? _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

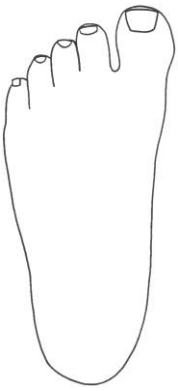
PATIENT NAME: _____

CURRENT PROBLEM

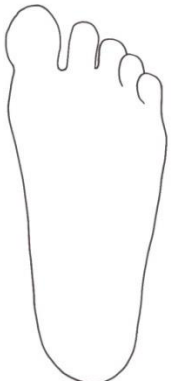
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT

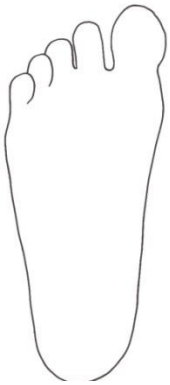


BOTTOM OF FOOT

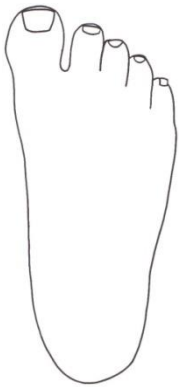
INSIDE OF FOOT

OUTSIDE OF FOOT

RIGHT FOOT



BOTTOM OF FOOT



TOP OF FOOT

OUTSIDE OF FOOT

INSIDE OF FOOT

HOW WOULD YOU DESCRIBE YOUR PAIN/PROBLEM? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING ☐ ITCHING ☐ SWOLLEN ☐ TENDER ☐ NUMB/TINGLING ☐ REDDENED ☐ OTHER_____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED ☐ GETS BETTER AND WORSE

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES ☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE ☐ RUNNING ☐ NOTHING ☐ OTHER _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

PATIENT NAME:_____

**I CERTIFY THAT I HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO LAWRENCE PODIATRY CENTER LLC ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS.

**LAWRENCE PODIATRY CENTER LLC MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE INFORMATION TO THE ABOVE NAMED INSURANCE COMPANY FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS. THIS CONSENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

**I understand that photographs or other digital images may be recorded to document my care, and I consent to this. Lawrence Podiatry Center LLC will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

**TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

**I acknowledge that I was provided a copy of the Notice of Privacy Practices in paper form or as posted in the office and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Please list any person other than the patient that may have access to medical files for the patient:

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

_____ _____

PRINT NAME OF PATIENT PRINT NAME OF PARENT OR GUARDIAN (IF APPLICABLE)

_____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT (IF APPLICABLE)