BK PODIATRY CENTERS, LLC

KARL B. COLLINS, D.P.M. BRIAN G. BROADHEAD, D.P.M. JARED VISSER, D.P.M.

LAST NAME _____, _____ **MI** ____ **FIRST NAME** _____

SEX: MALE FEMALE SS#____/____/_____ Age ____ DOB____/____/_____

Address1_____

Address2_____ City _____ State_____ Zip Code _____

Home # _____ Work # _____ Cell # _____ EMAIL _____

Occupation _____ Place of Work _____ Full Time Part Time

School _____ Full Time Part Time

Marital Status: Single Married Divorced Separated Widowed Minor Partner

Spouse/Partner's Name: _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone # _____

INSURANCE

Insurance Company_____

Subscriber's Name_____

Subscriber's SS#_____/____/_____ Subscriber's DOB _____/____/_____

2ND INSURANCE

Insurance Company_____

Subscriber's Name_____

Subscriber's SS#_____/____/_____ Subscriber's DOB_____/____/_____

PODIATRY HISTORY

Describe the primary reason for today's visit? (give which foot and any pain or disability)

_____

How would you rate your pain: 1 2 3 4 5 6 7 8 9 10

Have you seen a Podiatrist before? _____Dr._____ last apt _____

Is this a work related injury? _____ If yes, has your employer been notified? _____

DEMOGRAPHICS

Primary Language: English Spanish Other:

Race: Black or African American White Asian

Native Hawaiian or other Pacific Islander American Indian or Alaska Native

Are you Hispanic/Latino?_____

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MEDICAL HISTORY

Please circle any of the following problems that you have

Anxiety	Epilepsy	High Cholesterol	Psychiatric Care
Arthritis	Eye/Vision Problems	HIV/AIDS	Pulmonary Embolism
Asthma	Fatigue	Indigestion	Ringing in ears
Back Pain	Fever/Chills	Joint Pain/Discomfort	Seizure Disorders
Bleeding Problems	Fibromyalgia	Kidney Disease	Skin Problems
Cancer	Gerd	Migraines	Stomach Ulcer
Chest Pain	Headaches	Mitral Valve Prolapse	Stroke/TIA
COPD	Heart Attack	Muscle Pain	Swelling in Feet
Diabetes	Heartburn	Nose Bleeds	Thyroid Disease
Difficulty Breathing	Heart Disease	Numbness/Tingling	Urinary Problems
Dizziness	Hepatitis (A B C)	Prostate	Weight Change
Emphysema	High Blood Pressure	Psoriasis	

Other (Please List)_____

SOCIAL HISTORY

Do you drink alcohol_____ If yes how often _____

Do you use illegal drugs _____ Are you employed?_____How long do you stand?_____

Daily smoker Occasional smoker Former smoker Never a smoker

SURGERIES

Please list any surgeries (specifically within the last 5 years)

_____

_____

FAMILY HISTORY

Please specify if Mother (M), Father (F), or both (B)

Cancer _____ Diabetes_____ Foot Problems_____Heart_____ High Blood Pressure_____

Other:_____

MEDICATIONS

PLEASE LIST ALL MEDICATIONS AND DOSAGES OR PROVIDE A LIST

_____

_____

Local Pharmacy_____Location _____

ALLERGIES

ADHESIVE/TAPE	ASPIRIN	CODEINE	IODINE	LATEX
NOVOCAINE	PENICILLIN	SHELLFISH	SULFA DRUGS	XRAY DYE
OTHER				

Last Name_____ MI___First Name_____

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In order to make communications concerning appointments, treatment and billing matters easier, law requires our consent to release personal and health information.

Please list specific names of family members and/or friends that have your permission to obtain information from this office regarding your care and personal information.

Name Relationship

_____ _____

_____ _____

I give permission to leave a message on my: (Please circle)

Home answering machine work voicemail cell phone e-mail

Patient Name (Please Print):_____

Signature_____

Date_____

_____

Signature of patient representative if patient is a minor or an adult unable to sign.

Relationship to Patient: _____

Consent: Insurance Assignment and Release And/Or Medicare Authorization

I certify that I have insurance and/or Medicare/Medicaid services as indicated above. I hereby authorize direct payment of surgical/medical benefit to BK Podiatry, LLC for services rendered by him/her in person or under his/her supervision. I understand that I am responsible for any balance not covered by my insurance.

I authorize BK Podiatry, LLC to release any medical or incidental information that may be necessary for either medical care or in processing applications for medical benefits. I certify that the information given by me in applying of payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be valid as the original. My signature remains in effect until revoked by me in writing.

I consent to photography for the purpose of documentation.

Patient/Parent or legal Guardian signature_____ Date_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the notice

Patient Name (please print)_____ Date_____

Patient/Parent or Legal Guardian Signature _____

Consent of Treatment

I certify that all the above information is true and correct to the best of my knowledge. I give permission to the doctor and his assistants to administer and perform such procedures as may be deemed necessary in the diagnosis and or treatment of my podiatric condition.

_____

Signature of Patient or Authorized Representative Date

To be filled out by physician

I have reviewed this patient information document

_____

Signature of physician Date