IN ORDER TO FACILITATE TREATMENT, PLEASE ANSWER THE FOLLOWING QUESTIONS

Name_____ Date of Birth_____ Age_____

Local Address_____City_____State_____Zip_____

Permanent Address_____City_____State_____Zip_____

Telephone_____ Social Security Number_____

Employed by_____Occupation_____

Work Address_____ Work Telephone_____

Single____ Married____ Widowed____ Separated____ Divorced_____ Email: _____

Name of (Husband) (Wife) OR (Parent)_____

Employed by _____Occupation_____

Work Address_____ Work Telephone_____

Party Responsible of Payment of Account_____

Do you have Medical - Surgical Insurance? **YES** **NO**

Name of Company_____

Whom may we thank you for referring you to this office?_____

Name_____Address_____

MEDICAL HISTORY

Family Physician_____

Has he/she requested you be seen in our office?_____

Former Podiatrist_____

What did he/she treat you for?_____

_____

PRE-HISTORY FORM

State in your own words your medical reason(s) for coming to our office.

_____

_____

_____

Please list all medicines that you use._____

_____

_____

Please indicate by checking "**yes**" or "**no**" columns (two separate columns) if you have had significant problems in the below areas. Please comment on special problems.

Yes	No	Nature of Problem	Yes	No	Nature of Problem
		Heart			Diabetes
		Circulation			Skin
		High Blood Pressure			Anemia or Abnormal bleeding
		Chest Pain			Cramps in feet or legs
		Lungs (pneumonia, T.B., etc.)			Do you smoke? How much?
		Shortness of Breath (cough, pleurisy, wheezing)			Do you drink? How much?
		Liver Disease, Gallbladder			Allergic reaction to medications?
		Stomach trouble			Phlebitis
		Swelling in feet or ankles			Depression
		Arthritis			Nerves
		Kidney Disease or Stones			Psychiatric
		Allergies/Hayfever			Fainting or Convulsions
		Asthma			Strokes
		Low Back Pain			Pain in other areas
		Thyroid (Goiter)			Other Illnesses or problems
		Joint pain or stiffness			Gout
		Numbness in feet or legs			

Comments on above: _____

_____

_____

_____

Please give details of any... **(Type of operation and describe the injury)**

Operations	Approximate Date	Surgeon	Hospital
Serious Injuries			

******* COMPLETE AND SIGN (IN TWO PLACES) ON NEXT PAGE *******

Please inform us of any other important information:

_____

_____

_____

_____

DATE_____ _____

Signature of person filling out form

SIGNATURE ON FILE AUTHORIZATION

PATIENT'S FULL NAME_____**DATE**_____

Consent for Treatment, Insurance Authorization and Assignment

I hereby authorize the release of information to my insurance company concerning charges/treatment provided to me by the physicians of Advanced Podiatry; Dr. Michael Sekosky, Dr. Kathleen Richards, Dr. Raymond Botte. Transmittal by FAX is authorized. I hereby assign benefits to Advanced Podiatry. I understand that payment is due as services are provided unless I have authorized insurance billing. If, after 60 days, insurance payment has not been received, I understand that charges are my responsibility and payable immediately. In the event that payment is not made on this account and it is placed with a licensed collection agency, I/we agree to pay the fees of the collection agency equal to a maximum of 50% of our outstanding balance at the time of account is placed with the agency. Interest of 10% per year will be accrued on the principal balance. Should legal action also be necessary to collect the account, I/we agree to pay attorney's fees and court costs incurred for collection.

PATIENT'S SIGNATURE_____