1099 Ohio River BLVD
Sewickley PA, 15143

Sewickley Foot and Ankle

Dr Matthew G. Martin DPM

Phone: 412-741-4470
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Name:_____ Date of Birth:_____

Sex: ☐ Male ☐ Female ☐ Other_____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Other

Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Cell Phone:_____ SSN:_____

EMAIL: _____

Occupation:_____ ☐ Full Time ☐ Part Time ☐ Retired

Employer:_____ Work Phone: _____

Have you ever been seen by a podiatrist before? ☐ No ☐ Yes Name: _____

Reason for today's visit: _____

Previous treatment:_____ Injury? ☐ Yes ☐ No

Onset ☐ Sudden ☐ Gradual ☐ Chronic Duration:_____

Pain level 0 1 2 3 4 5 6 7 8 9 10 How did you hear about us? _____

Primary Care Provider: _____Phone: _____Date Last Seen: _____

Referring Provider: _____Phone: _____Date Last Seen: _____

Emergency Contact: _____Relationship:_____Phone:_____

Power of Attorney: _____Phone:_____ Code Status _____

May we leave personal medical information on the voicemail? ☐ No ☐ Yes: Cell or Home?

Information may also be released to:_____ Phone:_____Relationship:_____

Pharmacy:_____ Crossroads:_____Phone:_____

CURRENT MEDICATIONS: Include prescription drugs, over the counter, vitamins, hormones, etc.
Please include dose and frequency.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES: Please include type of reaction ☐ None ☐ Adhesive allergy ☐ Latex allergy

_____
_____
_____

Nicotine History: ☐ None ☐ Chew ☐ Vape ☐ Former Smoker ☐ Current Smoker ____Pack/Day # of years:_____

Alcohol History: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy How many drinks per week?_____

Are you able to care for yourself? ☐ Yes ☐ No Do you have difficulty walking or climbing stairs? ☐ Yes ☐ No

Do you have difficulty remembering things? ☐ Yes ☐ No Are you blind or have difficulty seeing? ☐ Yes ☐ No

Do you have transportation difficulties? ☐ Yes ☐ No Are you deaf or have difficulty hearing? ☐ Yes ☐ No

How is your general health? _____ Height: _____ Weight: _____

☐ **Diabetes (Type 1)** ☐ **Diabetes (Type 2)** ☐ **Pregnant/Nursing** ☐ **On Blood Thinners**

REVIEW OF SYSTEMS:

GENERAL:
- ☐ Malaise/Fatigue
- ☐ Recent trauma
- ☐ Recent antibiotics
- ☐ Vit B12 deficiency
- ☐ Regular exercise
- ☐ Fever
- ☐ Lethargy/Weakness
- ☐ Weight gain _____
- ☐ Weight loss _____
- ☐ Pregnant
- ☐ Birth defects
- ☐ Hearing problems

RESPIRATORY:
- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Sleep apnea

GASTROINTESTINAL:
- ☐ Nausea/Vomiting
- ☐ Abdominal pain
- ☐ Acid reflux
- ☐ Change in appetite

MUSCULOSKELETAL:
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Back pain
- ☐ Difficulty walking
- ☐ Leg swelling
- ☐ Muscle aches
- ☐ Leg cramps
- ☐ Fractures
- ☐ Joint swelling
- ☐ Red joints
- ☐ Degenerative disease

SKIN:
- ☐ Rash/Growths/lesions
- ☐ Non-healing lesion
- ☐ Itching/Dry skin
- ☐ Changes in hair/nails
- ☐ Change in skin color
- ☐ Laceration
- ☐ Excessive sweating

NEUROLOGIC:
- ☐ Numbness
- ☐ Tingling
- ☐ Burning
- ☐ Sciatica
- ☐ Drop foot

ENDOCRINE:
- ☐ Excessive thirst
- ☐ Frequent urination

CARDIOVASCULAR:
- ☐ Ankle swelling
- ☐ Chest pain on exertion
- ☐ Heart murmur
- ☐ Irregular heartbeat
- ☐ Palpitations
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Stent
- ☐ Valvular disease

OTHER:
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

PAST MEDICAL HISTORY:
- ☐ Anemia
- ☐ Angioplasty
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots/DVT
- ☐ Cancer, Type _____
- ☐ CHF
- ☐ Circulation Problem
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's/Ulcerative Colitis
- ☐ Dementia/Alzheimer's
- ☐ Depression
- ☐ Other _____
- ☐ Diabetes, Type _____
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Hepatitis, Type _____
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ High cholesterol
- ☐ Kidney disease, Stage_____
- ☐ Liver Disease
- ☐ Lung Disease

_____

- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Psoriasis
- ☐ Thyroid Disease ☐hypo ☐hyper
- ☐ Pacemaker/Defibrillator
- ☐ Radiation Treatment
- ☐ Raynaud's
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Stroke/TIA
- ☐ Valve Replacement, Type_____
- ☐ Wounds

_____

PAST SURGICAL HISTORY:
- ☐ Back Surgery
- ☐ Cardiac/Bypass Surgery
- ☐ Knee Surgery
- ☐ Hand / Wrist (circle)
- ☐ Hip Surgery
- ☐ Foot/Ankle (circle) Please Explain:
- ☐ Vascular Surgery
- ☐ Transplant, Type _____

_____

- ☐ Joint Replacement, Type: R/L_____
- ☐ Other _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received the attached copy of the **Notice of PrivacyPractices**.

Signature of Patient or Parent/Guardian/POA_____ Date_____

AUTHORIZATION

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Signature of Patient or Parent/Guardian/POA_____ Date_____

FINANCIAL POLICIES **Please read carefully and sign**

Co-payments will be collected at the time services are rendered. We accept payment in the form of cash, check, or credit card.

A $35.00 fee will be added to your account for returned checks. A $50 late fee will be assessed if payment is not received within 120 days from the first statement. Nonpayment of your account balance will result in collections and credit damage.

It is the practice of Sewickley Foot and Ankle P.C. to follow and be compliant with standards of the correct coding guidelines. **All medically necessary office visits and/or other procedures performed will be filed with your insurance company and are subject to copays, co-insurance and deductibles. You are required to pay any unmet deductible, co-insurance, co-payments, and any non-covered services and balances.**

While Sewickley Foot and Ankle makes multiple attempts to remind patients of their appointments, it is ultimately the patient's responsibility to keep their appointments or reschedule giving our office at least a full business day's notice. This courtesy allows the appointment to be offered to another patient. **"No shows" and same day cancellations may be assessed a $45 fee.**

Your signature below signifies your understanding and willingness to comply with these policies.

Signature of Patient or Parent/Guardian/POA_____ Date_____