ORNDOFF PODIATRY - Patient Information Form

PATIENT INFORMATION

First Name:_____ M.I.:_____
Last Name:_____
Address_____
_____
City_____ State____ Zip_____
Birthday_____/_____/_____ Age_____

eMail:_____
Electronic Notification: ☐ eMail ☐ Text

☐ Male ☐ Female ☐ Decline

☐ Single ☐ Married ☐ Widowed ☐ Divorced
☐ Separated ☐ Domestic Partner

PHONE NUMBERS

Home:_____ Work:_____
Cell:_____ Alt:_____

PRIMARY CARE PHYSICIAN (PCP)

PCP Name:_____
PCP Phone:_____ Fax:_____
Date last seen by PCP:_____

EMPLOYMENT

☐ Employed ☐ Unemployed ☐ Student
☐ Child ☐ Retired ☐ Other _____
Employer Name:_____
Employer Phone:_____

GUARANTOR/EMERGENCY CONTACT

Name:_____ Relationship:_____
Phone #:_____ Alt Phone #:_____

CURRENT FOOT ISSUE

☐ Bunion ☐ Ingrown Nail
☐ Diabetic Foot Care ☐ Injury
☐ Foot/Nail Care ☐ Orthotics
☐ Heel Pain ☐ Skin Condition
☐ Hammer Toe ☐ Warts
☐ Other_____

INSURANCE

Insurance Name:_____
ID Number:_____

On your behalf, we will submit medical service charges to your valid insurance company, providing that we have the most current information and ID card on file. If there are any changes to your policy, please notify us immediately. For your convenience we participate with most of the major insurance companies; however, you should contact your insurance company to determine if Orndoff Podiatry is participating in your network.

Additionally, you will be financially responsible for any deductibles, coinsurance, or non covered charges, should any of these apply to your insurance claim. It is recommended to contact your insurance company to verify your coverage prior to your visit. Some policies require a referral to see a specialist and it will be your responsibility to obtain the necessary documentation from your Primary Care Physician (PCP) and/or insurance company. Failure to do so could result in financial liability.

All specialist copays will be collected during the check-in process, and for your convenience, we accept cash, checks, VISA, MasterCard, Discover, and American Express. Any insurance remittance received will be assigned/paid to Orndoff Podiatry. In the event that a check is returned, you will be responsible for any associated fees. If for any reason you experience financial hardship, please mention it to one of our billing specialists and we will work with you to create a payment plan that meets your needs.

MEDICATIONS

List all Medications:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

☐ Check here if you are currently taking any type of blood thinner, including aspirin.

Pharmacy Name:_____
Pharmacy Phone:_____

REVIEW OF SYSTEMS

Constitutional	Cardiovascular	Endocrine	Gastrointestinal
☐ Chills	☐ Swelling Feet/Hands	☐ Increased Thirst	☐ Heart Burn
☐ Fever	☐ Calf Cramping	☐ Fatigue	☐ Diarrhea
☐ Varicose Veins	☐ Cold Feet	☐ Increased Hunger	☐ Constipation

Immunology	Lymphatic	Respiratory	Neurology
☐ Arthritis Flare Up	☐ Inable to stop Bleeding	☐ Asthma	☐ Burning
☐ Gout		☐ COPD	☐ Numbness
			☐ Neuropathy

Skin			Musculoskelatal
☐ Athlete's Foot	☐ Blisters	☐ Eczema	☐ Back Pain
☐ Itchy Skin	☐ Rash	☐ Burning Feet	☐ Heel Pain
☐ Sensitive Skin	☐ Dermatitis	☐ Leg Ulcers	☐ Joint Stiffness
☐ Non-Healing Wound	☐ Excessive Scars		☐ Joint Swelling
			☐ Weakness

☐ Other_____

PAST MEDICAL HISTORY

☐ AIDS/HIV+	☐ Diabetes	☐ High Blood Pressure	☐ Never Smoked
☐ Arthritis	☐ Gout	☐ High Cholesterol	☐ Currently Smoke
☐ Cancer	☐ Heart Disease	☐ Respiratory Disease	☐ Quit mm/dd/yyyy
☐ Other_____		☐ Stroke	☐ Other Tobacco Use

SMOKING HISTORY

ALLERGIES

☐ No Known Allergies	☐ Aspirin	☐ Iodine	☐ Novocaine
☐ Adhesive/Tape	☐ Codeine	☐ Latex	☐ Penicillin
☐ Anti-Inflammatories	☐ Demerol	☐ Local Anesthetic	☐ Sulfa

☐ Other_____

I agree to each of the policies presented and attest that the above information is correct. I also grant permission to medical treatment as deemed necessary in the diagnosis and/or treatment of my feet.

Printed Name:_____

Signature:_____ Date:_____

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