PODIATRY ASSOCIATES OF CINCINNATI, INC.

PATIENT INFORMATION • PRINT FIRMLY & CLEARLY

(Circle One) Doctor Mr. Ms. Mrs.	Patient's First Name	Middle Name	Last Name	Home Phone	Spouse's Name

Patient's Home Address Number/Street/City/State/Zip

Patient's Employer	Business Phone

Employer's Address	Preferred Pharmacy / Phone #

Age	Sex	Birth Date	Social Security No.	Email
			— —	

Preferred Language	Race	Ethnicity

Do you authorize Podiatry Associates of Cincinnati and Medical Billing Strategies to contact you via email? ❑ YES ❑ NO

INSURANCE POLICY INFORMATION - all fields required.
Primary Insurance Coverage

Insurance Policy Holder Name	Relationship to Patient	Policy Holder Date of Birth	SSN of Policy Holder
			— —

Insurance Policy Name

Policy ID#	Group#

SECONDARY INSURANCE COVERAGE

Secondary Insurance Policy Holder Name	Relationship to Patient	Policy Holder Date of Birth	SSN of Policy Holder
			— —

Insurance Policy Name

Policy ID#	Group#

MEDICAL INFORMATION

Who is your primary care physician (family physician)

First Name	Last Name	Last Seen

Who referred you to this office?

❑Physician ________________ ❑Patient ________________ ❑Other ________________

In Case of Emergency

Name	Address	Phone Number

I give permission to Podiatry Associates of Cincinnati, Inc. to administer treatment for my foot and ankle conditions. I understand that I,or my legal representative, am financially responsible for all services rendered whether covered by insurance or not. I, or my legal representative, am also responsible for all fees incurred if no referral is receieved for my care.

I, or my legal representative, authorize the release of any medical or other information necessary to process my insurance claims. I, or my legal representative, authorize payment of medical benefits directly to Podiatry Associates of Cincinnati, Inc. and I understand I, or my legal representative, am responsible for any unpaid balance on my account.

Signature ________________________________ Date ____________

MEDICAL HISTORY

Describe your current foot problem: ______________________ How long? ________

Describe onset: ____________ Previous Treatments: ______________________

Are you allergic to any medications (drugs)? ❑ YES ❑ NO If so, please list.

____

____

List all medications you are currently taking (please include Aspirin, Tylenol, Vitamins and Birth Control Pills). If you are not currently taking any medications, please write NONE or N/A on line one.

1.____________ 2. ____________ 3.____________ 4.____________

5.____________ 6. ____________ 7.____________ 8.____________

Previous Surgeries & Hospitalizations: ( ) NONE

1. ____________ 2. ____________ 3. ____________

4. ____________ 5. ____________ 6. ____________

Please check if you have had a history of any of the following:

	YES	NO		YES	NO		YES	NO
Are you currently pregnant?			GI or Rectal Bleeding			Lung Disease		
Anemia			Gout			Night cramps		
Arthritis			Heart disease			Phlebitis		
Asthma			Hepatitis			Psychiatric condition		
Cancer			High Cholesterol			Skin problems		
COPD			Hypertension			Sexually transmitted diseases		
Depression			Kidney disease			Thyroid disease		
Diabetes			Leg pain			Tuberculosis		

Please describe: Other illnesses or diseases which are not listed:

FAMILY HISTORY

Please check if mother or father have a history of any of the following:

	Mother	Father	NO		Mother	Father	NO
Arthritis				Diabetes			
Asthma				Heart disease			
Bunions				Kidney disease			
Cancer				Lung disease			

SOCIAL HISTORY

What is your approximate weight? lbs. Height? ft. in. Shoe size

What is your current occupation? How many hours per day do you stand?

Do you smoke cigarettes? ❑ YES ❑ NO ❑ FORMER If yes, how many packs per day?

Do you drink alcohol? ❑ YES ❑ NO If yes, how many drinks per week?

Do you use recreational drugs? ❑ YES ❑ NO

AUTHORIZATION

I have reviewed the information on the questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status or medications, I will inform the doctor.

Signature ______________________________ Date ______________