Comprehensive Foot Centers, PA
PATIENT INFORMATION FORM

Name First_______________ M.I.______ Last_______________

Address _______________ Apt.______ City_______________ State______ Zip______

Home Phone (_____)_______________ **Cell Phone** (_____)_______________ **Email**_______________

SSN_______________ **Patient's Employer**_______________ **Phone** (_____)_______________

Emergency Contact Name_______________ **Relationship**_______________ **Phone**( )_______

How did you hear about us? □ Insurance □ Family/Friend □ Website □Other_______________

□Doctor_______________

Person Responsible for Account: □ **Self** □ **Parent** □ **Spouse** □ **Guardian**

Name First_______________ M.I.______ Last_______________

Address _______________ Apt.______ City_______________ State______ Zip______

DOB__________ **SSN**__________ **Home Phone** (_____)__________ **Cell Phone** (_____)__________

Employer_______________ **Phone** (_____)_______________

Primary Insurance

Insurance Plan_______________ **Effective Date**__________ **Specialist Co-Pay$**__________

Policyholder Name_______________ **Relationship to Patient**_______________

Policyholder Address _______________ City_______________ State______ Zip______ Phone______

PolicyholderDOB_______________ **Policy HolderSSN**_______________

Policyholder Employer_______________ **Phone** (_____)_______________

Secondary Insurance

Insurance Plan_______________ **Effective Date**__________ **Specialist Co-Pay$**__________

Policyholder Name_______________ **Relationship to Patient**_______________

Insurance Address _______________ City_______________ State______ Zip______ Phone______

PolicyholderDOB_______________ **Policy HolderSSN**_______________

Policyholder Employer_______________ **Phone** (_____)_______________

Assignment of Insurance Benefits/Release of Medical Information

I hereby authorize treatment deemed necessary by the physicians of Comprehensive Foot Centers, PA. I also authorize the release of medical records to any insurance company with whom I have health insurance coverage or to any company to which I have applied for coverage. I request payment of medical insurance benefits including major medical to be made directly to Comprehensive Foot Centers, PA on any unpaid bills for services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Parent/Guardian_______________

Signed_______________

Date_______________

Turn Page Over

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PATIENT INFORMATION FORM

Name First____________________ M.I.______ Last____________________

Age__________ **Date of Birth**__________ **Sex: M or F Marital Status: S M D W**

Your Family Doctor:____________________ **Date of Last Visit**__________

Address:____________________ **Phone (   )**__________

Allergies: ☐ No Known Allergies ☐ Adhesive/Tape ☐ Anticoagulant Therapy ☐ Aspirin ☐ Codeine

☐ Demerol ☐ Local Anesthetics ☐ Novocain ☐ Penicillin ☐ Seafood ☐ Sulfa ☐ Other__________

Athletic Activities in which you participate____________________

Cigarett/Tobacco use ☐ Yes ☐ No Years Used__________ How much a day?__________

Medications:____________________

Medical History Please place a mark in the "yes" or "no" boxes below to indicate whether you have any of the following:

AIDS/HIV	☐ Yes	☐ No	Circulatory Problems	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Allergies to Anesthetic	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Foot or Leg Cramps	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Heart Valves or joints	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
			Heart Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Swelling in Ankles/Feet	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis or Jaundice	☐ Yes	☐ No	Tired Feet	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hysterectomy	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Chronic Diarrhea	☐ Yes	☐ No						

Have you ever seen a podiatrist before? ☐ Yes ☐ No Name__________ Last Visit__________

What is your chief complain for which you came to be treated?__________
Please circle the area on the pictures below that is the problem area.