

(812) 448-9290

FAX (812) 448-9296

PATIENT INFORMATION

Date _____

Name (First) _____ (MI) _____ (Last) _____

Soc.Sec # _____ Birthdate _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Sex M F Single Married Divorced Widowed Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

In case of emergency who should be contacted? _____

Phone _____

Person responsible for account _____

Relationship to patient _____ Birthdate _____ Soc.Sec# _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible party employed by _____ Occupation _____

Business Phone _____ Business Address _____

Whom may we thank for referring you? _____

Where did you hear about us? (Check all that apply)

- Brazil Times Ad Radio
- Tribune Star Ad Friend/family member
- Wabash Valley Extra other _____

PRIMARY INSURANCE -

SECONDARY INSURANCE -

ADDITIONAL INSURANCE -

Name of Doctor who follows your diabetes: _____

Date of last visit with this diabetes Doctor: _____

How often do you check your blood sugar at home? _____

Blood sugar this morning? _____ Last HgA1C (3 month test) _____

Patient Name _____ Date of birth _____

MEDICAL HISTORY

Reason for visit _____

Primary Care Physician _____

When was your last Primary Care Physician's office visit? _____

Height _____ Weight _____

- 1. Do you smoke? YES NO
- 2. Do you use alcohol? YES NO
- How many years? _____ # packs per day _____
- 3. Do you use illegal drugs? YES NO
- 4. Has anyone in your family had: diabetes heart disease foot problems

5. Have you had any allergic reactions to the following:

- Local anesthetics (eg novocaine)..... YES NO
 - Penicillin..... YES NO
 - Sulfa Drugs..... YES NO
 - Sedatives..... YES NO
 - Iodine..... YES NO
 - Aspirin..... YES NO
 - Latex..... YES NO
 - Other..... YES NO
- Please describe _____

6. Are you currently taking any medications? YES NO

Herbal supplements YES NO Vitamins YES NO

Please list medications (or provide your list to be copied) _____

7. Please list any surgeries you have had _____

8. Have you ever had any of the following? (check those that apply)

- | | | |
|---|--|--|
| Anemia <input type="checkbox"/> | Heart Murmur <input type="checkbox"/> | Polio <input type="checkbox"/> |
| Anorexia <input type="checkbox"/> | Heart Disease <input type="checkbox"/> | Prostate Problem <input type="checkbox"/> |
| Arthritis <input type="checkbox"/> | Hepatitis - A - B - C <input type="checkbox"/> | Psychiatric Care <input type="checkbox"/> |
| Asthma <input type="checkbox"/> | Hernia <input type="checkbox"/> | Respiratory Disease <input type="checkbox"/> |
| Back Problems <input type="checkbox"/> | Herpes <input type="checkbox"/> | Rheumatoid Arthritis <input type="checkbox"/> |
| Bleeding Tendency <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/> | Rheumatic Fever <input type="checkbox"/> |
| Blood Disease <input type="checkbox"/> | HIV/AIDS <input type="checkbox"/> | Scarlet Fever <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | Jaundice <input type="checkbox"/> | Stroke <input type="checkbox"/> |
| Chemical Dependency <input type="checkbox"/> | Kidney Disease <input type="checkbox"/> | Thyroid Problems <input type="checkbox"/> |
| Chemotherapy <input type="checkbox"/> | Liver Disease <input type="checkbox"/> | Tonsillitis <input type="checkbox"/> |
| Chicken Pox <input type="checkbox"/> | Low Blood Pressure <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> |
| Circulatory Problems <input type="checkbox"/> | Measles <input type="checkbox"/> | Ulcer <input type="checkbox"/> Stomach <input type="checkbox"/> Other <input type="checkbox"/> |
| Congenital Heart Lesions <input type="checkbox"/> | Migraine Headaches <input type="checkbox"/> | Venereal Disease <input type="checkbox"/> |
| COPD <input type="checkbox"/> | Mitral Valve Prolapse <input type="checkbox"/> | Any Other Condition <input type="checkbox"/> |
| Diabetes <input type="checkbox"/> | Mumps <input type="checkbox"/> | Please describe _____ |
| Emphysema <input type="checkbox"/> | Multiple Sclerosis <input type="checkbox"/> | _____ |
| Epilepsy <input type="checkbox"/> | Pacemaker <input type="checkbox"/> | _____ |
| Glaucoma <input type="checkbox"/> | Pneumonia <input type="checkbox"/> | |

9. Have you experienced any of the following in the last month?

- Chest Pain
- Nausea/Vomiting
- Shortness of Breath
- Cough – persistent or bloody
- New joint pain
- Sinus Trouble
- Diarrhea
- Numbness/Tingling hands feet
- Skin Rash
- Difficulty/Pain Urinating
- Persistent Headache

AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE CLAY COUNTY PODIATRY, LLC to release information requested by my insurance carrier and/or Workers Compensation carrier. Additionally, I authorize CLAY COUNTY PODIATRY, LLC to release information to any hospital or physician I may be referred to by this health care provider.

Date _____

Signature _____

Relationship to Patient _____

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE assignment and payment directly to CLAY COUNTY PODIATRY, LLC of any major medical benefits and/or Medicare due me. I understand that insurance may not and that Medicare does not pay one hundred percent (100%) of the medical charges.

I HEREBY ACKNOWLEDGE and agree to pay any and all charges that exceed or that are not covered by insurance and/or Medicare, including any deductible, I also acknowledge that I am responsible for reasonable interest, collection fees, attorney fees for the greater of a) forty percent (40%) or b) \$300.00 of the outstanding balance, and/or court costs incurred in connection with any attempt to collect amounts I may owe.

Date _____

Signature _____

CONSENT FOR TREATMENT

I hereby request and voluntary consent to such office care, including routine diagnostic procedures and medical treatment as may be deemed necessary by MIRANDA GOODALE, DPM and/or her designees.

Date _____

Signature _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have been provided a copy of CLAY COUNTY PODIATRY, LLC Notice of Privacy Practices.

Date _____

Signature _____

OFFICE USE ONLY

Date acknowledgment received: _____

-OR-

Reason acknowledgment was not obtained:
