

Welcome to Shenandoah Podiatry

Date _____

Name: First _____ MI _____ Last _____

Sex _____ Date of Birth _____ SS# or Driver's Lic. # _____

Address _____

City _____ State _____ Zip _____

Email Address _____ Home Phone _____

Employer _____ Cell Phone _____

Race _____ Ethnicity _____ Work Phone _____

How did you hear about us? Physician/Friend/Insurance/Sign/Internet/Phonebook/Other: _____

.....
Emergency Contact Information

Name _____ Relationship _____

Address _____

Home Phone _____ Work Phone _____

.....
All patients please read and sign below:

WE WILL file your insurance claim for you due to the complexities involved. Although this service is provided free of charge, it does not relieve you of any financial responsibility.

By signing this you:

- Authorize Shenandoah Valley Podiatry Associates, Ltd. (SVPA) to furnish medical photographic, or other information to insurance carriers as well as any other physician we may refer you to concerning your injury, disease, and treatment
- Assign to SVPA all payments for medical services and/or supplies
- Agree to pay any applicable service charges, collection agency costs or legal fees plus court costs should the account be declared overdue or delinquent
- Hereby attest that the information on this form is true to the best of your knowledge

Signature _____ Date _____

HIPPA PRIVACY POLICY

We are required by applicable federal and state laws to maintain the privacy of your protected health information. A copy of the Notice of Health Information Practices is posted for your review or you may request a copy at the front desk. By signing this notice you attest that you are aware of and understand the policy.

Signature _____ Date _____

Medical Information

This information is important for our records and your health

Name _____

Date _____

Why did you make this appointment? (Describe your foot problem)

How long has it been bothering you? _____

Are you allergic or sensitive to:

- | | | | |
|-------------------------------------|---|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Novocaine |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Cephalosporins | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Other _____ | | |

Please list all of your medications (or give list to receptionist to copy):

Check any of the following you have, or have had a problem with:

- | | | | |
|---|---|--|---------------------------------|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Liver |
| <input type="checkbox"/> Acid Reflux (GERD) | <input type="checkbox"/> Kidneys | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Lungs |
| <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Gout | | |
- Any other condition not mentioned _____
-

Have you had any of these surgeries?

- | | | | |
|---|---------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Appendix | <input type="checkbox"/> Foot | <input type="checkbox"/> Heat by-pass |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Heart valve | <input type="checkbox"/> Tonsils |
| <input type="checkbox"/> C-section | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Vascular | |
| <input type="checkbox"/> Cancer, where? _____ | <input type="checkbox"/> Other _____ | | |

Have you been admitted to the hospital in the past 12 months? For what? _____

Family Physician _____ Date you last saw this doctor _____

Preferred Pharmacy _____

Is there a family history of:

- Heart problems Arthritis Diabetes Bunions
 Circulation problems Flatfeet Bleeding disorder

Do you currently smoke? Yes No # packs per day _____ # of years _____

Did you previously smoke? Yes No # of years _____

Do you drink alcohol or beer? Yes No # of drinks per week _____

Employment: Sit at job Stand at job Varies

Check if you currently have any of the following symptoms:

General

- Chills
 Fever
 Dizziness

Cardiovascular

- Chest pain
 Swelling in ankles
 Cold feet
 Leg cramps

Skin

- Easy bruising
 Sores that won't heal
 Rash
 Changes in moles

Muscle/Joints/Bones

- Pain
 Weakness
 Difficulty walking

Neurological

- Numbness
 Burning/tingling
 Loss of coordination

Gastrointestinal

- Poor appetite
 Diarrhea
 Nausea/Vomiting

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's signature _____ Date _____