_____ **RICHARD ALTWERGER, D.P.M.** _____ **TIMOTHY FAULER , D.P.M.** _____ **SCOTT ALTMAN, D.P.M.**

SCHODACK PODIATRY

PATIENT INFORMATION FORM

(PLEASE PRINT)

PLEASE PRESENT YOUR INSURANCE CARD UPON ARRIVAL

Date: / / EMAIL:

Patient Name: **Date of Birth:** **Sex: M F**

Last First MI

Home Address: City/State: Zip:

HOW DO YOU PREFER TO BE REMINDED OF YOUR APPOINTMENT: PHONE TEXT EMAIL

Home Phone#: Work/Cell: **SS #:**

MARITAL STATUS : SINGLE MARRIED WIDOWED SEPARATED # OF CHILDREN:

WHO DO YOU LIVE WITH: ETHNICITY:

SPOUSE/PARTNER NAME: DATE OF BIRTH:

EMPLOYEMENT STATUS: PART TIME FULL TIME RETIRED DISABLED STUDENT: PART TIME FULL TIME

EMPLOYER NAME: PHONE #:

EMPLOYER ADDRESS CITY/STATE: ZIP:

DO YOU HAVE A LEGAL GUARDIAN, HEALTHCARE POWER OF ATTORNEY OR HEATHCARE ADVOCATE? YES NO

IF YES NAME: RELATIONSHIP PHONE #:

EMERGENCY CONTACT: RELATIONSHIP PHONE #:

PRIMARY CARE DOCTOR: **PHONE #:** **DATE LAST SEEN:**

PHARMACY: LOCATION: PHONE#:

HOW WERE YOU REFERRED TO OUR OFFICE:

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

YES NO NAME(S):

WHO IS RESPONSIBLE FOR PAYMENT? RELATIONSHIP TO PATIENT:

ADDRESS: CITY/STATE: ZIP: PHONE#:

MY SERVICES WILL BE PAID TODAY BY **CASH** **CHECK** **MC** **VISA**

PATIENT NAME: **DATE OF BIRTH:** **DATE:**

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: **PHONE #:**

ADDRESS: CITY/STATE: ZIP:

INSURED NAME: DATE OF BIRTH EMPLOYER

ID# GROUP#: RELATIONSHIP TO INSURED

SECONDARY INSURANCE COMPANY NAME: **PHONE #:**

ADDRESS: CITY/STATE: ZIP:

INSURED NAME: DATE OF BIRTH EMPLOYER

ID# GROUP#: RELATIONSHIP TO INSURED

ALLERGIES:

HAVE YOU EVER HAD ANY ADVERSE SIDE EFFECTS OR ALLERGIES TO:

Y/N		**Reaction**	**Y/N**		**Reaction**
	Adhesive Tape			Novacaine	
	Anticoagulants			Peanuts	
	Aspirin			**Penicillin**	
	Codeine			Seafood	
	Cortisone			**Sulfa drugs**	
	Iodine			Other antibiotics	
	Latex			Other Pain Meds	
	Metal/Jewelry			Other	

MEDICATIONS:

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTION, OVER THE COUNTER MEDS AND HERBAL SUPPLEMENTS): (IF YOU HAVE A LIST WE WILL BE HAPPY TO COPY IT)

NAME	**MG**	**DOSAGE**	**NAME**	**MG**	**DOSAGE**

PATIENT NAME:_____ **DATE OF BIRTH:** **DATE**_____

HAVE YOU OR A FAMILY MEMBER EVER BEEN TREATED FOR ANY OF THE FOLLOWING CONDITIONS? IF SO PLEASE CIRCLE THE APPROPRIATE LETTER THAT APPLIES TO THOSE CONDITIONS IN THE BOX NEXT TO THE CONDITION.

S = SELF **M = MOTHER'S SIDE** **F = FATHER'S SIDE** **B = BROTHER** **S = SISTER**

S M F B S	ACID REFLUX	S M F B S	GLAUCOMA	S M F B S	MRSA
S M F B S	ANEMIA	S M F B S	HEADACHES	S M F B S	MUSCLE OR JOINT PAIN
S M F B S	ARTHRITIS	S M F B S	HEART ATTACK	S M F B S	PHLEBITIS
S M F B S	ASTHMA	S M F B S	HEART DISEASE	S M F B S	PERIPHERAL ARTERIAL DISEASE
S M F B S	BLEEDING DISORDER	S M F B S	HEARING LOSS	S M F B S	PARKINSON'S DISEASE
S M F B S	CANCER	S M F B S	HEPATITIS A B C	S M F B S	POOR CIRCULATION
S M F B S	CATARACTS	S M F B S	HIGH CHOLESTEROL	S M F B S	RESPIRATORY DISEASE
S M F B S	CIRCULATION PROBLEM	S M F B S	HIV/AIDS	S M F B S	RHEUMATIC FEVER
S M F B S	DEPRESSION	S M F B S	HYPERTENSION	S M F B S	SHORTNESS OF BREATH
S M F B S	DIABETES	S M F B S	HYPERTHYROIDISM	S M F B S	SEIZURE DISORDER
S M F B S	DIGESTIVE PROBLEMS	S M F B S	HYPOTHYRDOIISM	S M F B S	STROKE
S M F B S	DIZZINESS	S M F B S	IBS	S M F B S	STOMACH ULCERS
S M F B S	ECZEMA	S M F B S	KIDNEY DISEASE	S M F B S	TB/LUNG DISEASES
S M F B S	EPILEPSY	S M F B S	LIVER DISEASE	S M F B S	THYROID DISORDER
S M F B S	FATIGUE	S M F B S	LYME DISEASE	S M F B S	VARICOSE VEINS
S M F B S	FIBROMYALGIA	S M F B S	MEMORY LOSS	S M F B S	
S M F B S	FRACTURES	S M F B S	NERVOUS DISORDER	S M F B S	
S M F B S		S M F B S		S M F B S	

PRIOR SURGERIES:

TYPE OF SURGERY **DATE** **TYPE OF SURGERY** **DATE**

HEIGHT **WEIGHT:** **SHOE SIZE:**

SOCIAL HISTORY:

DO YOU CURRENTLY USE CIGARETTES OR TOBACCO? YES NEVER QUIT

IF YES, FOR HOW LONG? HOW MANY PACKS/DAY? IF QUIT, WHEN?

ALCOHOL USE? YES NO HOW MUCH? DAILY WEEKLY SOCIAL

DO YOU USE RECREATIONAL DRUG(S): YES NEVER QUIT

HOW LONG AGO DID YOU QUIT? TYPE OF DRUG(S)

CURRENT USE - TYPE OF DRUG(S) RARE OCCASIONAL MODERATE DAILY

DO YOU DRINK CAFFEINE PRODUCTS? YES NO TYPE: HOW MANY CUPS PER DAY

PATIENT NAME:_____ **DATE OF BIRTH:** **DATE**

PODIATRIC HISTORY:

FEMALES ONLY: ARE YOU PREGNANT OR NURSING A CHILD? YES _____ **NO** _____

HAVE YOU EVER SEEN A PODIATRIST BEFORE? YES NO **DIABETICS: YOUR A1C**

DOCTOR YOU SEE FOR YOUR DIABETES **DATE LAST SEEN:**

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY:

WHEN DID THE PROBLEM BEGIN?_____ ANY INJURIES TO THIS AREA YES NO

IF AN INJURY WHEN: HOW:

HAVE YOU RECEIVED PRIOR TREATMENT FOR THIS CONDITION: YES NO WHERE?

WHAT TYPE OF TREATMENT_____

CIRCLE THE DEGREE OF PAIN YOU ARE CURRENTLY EXPERIENCING:

NO PAIN: MINIMAL 1 2 3 4 5 6 7 8 9 10 SEVERE

HAVE YOU EVER HAD ANY OF THE FOLLOWING FOOT CONDITIONS?

	ANKLE INSTABILITY		FLAT FEET		INGROWN TOE NAILS		SWEATING/ODOR
	ARTHRITIS		FRACTURES		JOINT PAIN		TENDONITIS
	BACK PAIN		FUNGAL INFECTIONS		KNEE PAIN		TINGLING IN FEET
	BLISTERS		GOUT		NUMBNESS IN FEET		TIRED FEET
	BONE SPURS		HAMMERTOES		PLANTAR FASCIITIS		ULCERS
	BUNIONS		HEEL PAIN		PRONATION		WARTS
	BURNING FEET		HIP PAIN		SHIN SPLINTS		
	CORNS/CALLUSES		INFECTIONS		SPRAINS		

SPORTS & ACTIVITIES:

SIGNATURE ON FILE AND PERMISSION TO TREAT:

- I request that payments of authorized benefits be made on my behalf for any services provided through Schodack Podiatry.
- I authorize any holder of information regarding my treatment, to release any and all information needed to determine these benefits to the insurance company.
- I understand that the information provided on this form is true and correct to the best of my knowledge.
- I recognize my financial obligation of any coinsurance, co-pays, or deductibles and non-covered services that may be required are due and payable at the time of service.
- I hereby give permission to Schodack Podiatry and any qualified staff to evaluate, diagnose and treat my foot condition as may be deemed necessary.

Patient or Authorized Signature:_____ Date:_____

If not Patient state relationship:_____