NEW PATIENT HISTORY

Patient Name_____Date_____

Briefly describe your foot problems_____

How long have you had this problem? _____

How is this problem affecting your daily life? _____

_____

How is this problem affecting your health? _____

_____

What are you unable to do (that you would like to do) because of this problem_____

_____

Have you been treated for this problem before?_____

Briefly describe any past treatment_____

What would be the ideal outcome of our work together?_____

_____

PAST MEDICAL HISTORY

ADULT DISEASE (please check):

High Blood Pressure:_____ Diabetes _____ Arthritis_____ Hepatitis_____

Anemia_____ Other (Please List): _____

PREVIOUS SURGERIES:

_____

INJURIES: _____

HOSPITALIZATIONS:

_____

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and /or medical staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above.) Release of Information): I authorize the release of any medical information necessary to process this claim.

(HIPAA) Privacy):

- ☐ **I acknowledge that I received my HIPPA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.**
- ☐ **I decline to take a copy of the notice of privacy practice.**

Patient Signature:

_____