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

Please list Family History:_____

_____

Adult Disease (Please Check):

High Blood Pressure:_____Diabetes:_____Arthritis:_____ Hepatitis:_____Anemia:_____HIV:_____

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 HIPAA 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 practices.

Patient Signature:

_____