Practice: Huguenot Podiatry Group PC **Today's Date:**

First Name: _____ **Last Name:** _____ **DOB:** _____

Sex ☐M ☐F **Marital Status:** ☐ Single ☐Married ☐ Widowed ☐ Divorced **SS#:** _____

E-mail: _____ **Spouse/Partner Name**: _____

Emergency Contact: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone #: _____ ☐ Check if preferred **Cell #:** _____ ☐ Check if preferred

Employer/Occupation: _____ **Phone:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

INSURANCE INFORMATION

Primary Insurance: _____ Are you the Insured? ☐Yes ☐No

If you are Not the insured, what is your Relationship to insured:

Insured's Full Name: _____

Insured's Date of Birth: ___/___/___

Secondary Insurance: _____

How did you find out about our practice? ☐Physician ☐ Internet ☐ Telephone book ☐ Family

Other:_____

What is the reason for your visit today? _____

_____ **Result of accident or work injury?** ☐Yes ☐No

How long has this bothered you? _____

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing

PLEASE READ AND SIGN ALL PAGES:

The above information 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.

Patient Signature: _____ Date: _____

History and Physical

Name: _____ **DOB:** _____

Medical History: Please List All Your Medical Conditions:

Do you have Diabetes? ☐ Yes ☐ No

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Are you pregnant or nursing? _____

Surgical History:

Please List All Previous Surgeries:

_____

_____

_____

_____

_____

_____

_____

Do you take any Medications? ☐ Yes ☐ No

List All Medicines that you take:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Do you have Allergies?

☐ **Yes** ☐ **No**

List Allergies:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Do You Smoke? ☐ **Yes** ☐ **No**

Preferred Language: _____

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Referring Physician: _____ Phone**:** _____ Date Last Seen: _____

Address: _____

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. I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____