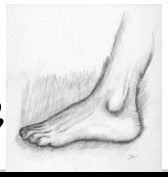
Welcome



Lighthouse Foot & Ankle

PATIENT INFORMATION

Date _____ Patient SS# _____
Patient Name _____
Address _____

Sex: ☐ M ☐ F Age ____ Date of Birth _____
Spouses Name _____
Marital Status:
☐ Single ☐ Married ☐ Widowed
☐ Divorced ☐ Separated
Occupation _____
Employer _____
Employer Address _____
Employer Phone _____
Whom may we thank for referring you?
Dr. _____ Source _____
Primary Doctor _____
Pharmacy Name _____
Phone _____
Zip Code _____

Phone Numbers

Home _____ Work/Cell _____
Email _____
IN CASE OF AN EMERGENCY, CONTACT:
Name _____
Phone # _____

INSURANCE

Who is responsible for this account (insured)? _____
Relationship to the insured _____
Primary Insurance Co. _____
Policy # _____
Secondary Insurance Co. _____
Policy# _____

Assignment & Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign to Dr. D'Altilio all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. D'Altilio to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

x
Responsible Party Signature _____

Relationship _____ **Date** _____

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or my behalf holder Dr. D'Altilio for any services furnished to me by her. I authorize any holder of medical information about me to release to the Health Care Financing Administration covered services. and its agents any information to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance, is indicated in item 9 of the HCFA-1500 for, or elsewhere on other approved claim forms electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency show. In Medicare assigned cases, the physician or supplier agrees to acceptance charge determination of the Medicare carrier as the full charge, and the penitent is responsible only for the deductible, coinsurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature x _____

PODIATRIC HISTORY

What is the **problem** for which you came to be treated? _____

How long have you had this problem? _____

What previous treatment have you had for this problem? _____

Do you have back pain? Yes No

Do you have knee pain? Yes No

Do you have swelling in your ankles? Yes No

Do you have swelling in your feet? Yes No

Do you have arch pain? Yes No

Have you or anyone in your family had any of the following's the past year?

Ankle Pain	Yes	No
Athletes Foot	Yes	No
Bunion	Yes	No
Corns & Calluses	Yes	No
Cramps or Numbness in Feet or Legs	Yes	No
Flat Feet	Yes	No
Fungal nails	Yes	No
Heel Pain	Yes	No
Ingrown Toenails	Yes	No
Plantar Warts	Yes	No
Swelling in Ankles or Feet	Yes	No
Arch pain	Yes	No

PAST MEDICAL HISTORY

Please check "Yes" or "No" to indicate if you have any of the followings:

AIDS/HIV	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Sickle Cell	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Stomach-Ulcers	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hepatitis or Jaundice	☐ Yes	☐ No	Varicose-Veins	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Other _____		
Cancer	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No			
Cataracts	☐ Yes	☐ No	Kidney Problem	☐ Yes	☐ No			
Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No			
Dialysis	☐ Yes	☐ No	Mental disorder	☐ Yes	☐ No			
Depression	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No			
			Rheumatic Fever	☐ Yes	☐ No			

Previous Surgeries _____

Personal/Social History _____ Height_____ Weight_____ Shoe size_____

Alcohol use: ☐ Yes ☐ Occasionally/Socially ☐ No

Cigarette/Tobacco use: ☐ Yes ☐ No If yes (pack per year)_____

Years smoked_____

Please list physical activities in which you participate and indicate frequency: _____

FAMILY HISTORY (DOES ANYONE IN YOUR FAMILY HAVE THE FOLLOWING?)

☐ Stroke	☐ Arthritis	☐ High Blood Pressure	☐ Other _____
☐ Cancer	☐ Kidney Disease	☐ Flat Foot	
☐ Diabetes	☐ Osteoporosis	☐ Seizures	

MEDICATIONS & VITAMINS : INCLUDE PRESCRIPTIONS,OVER THE COUNTER

ALLERGIES

None ☐

SHELLFISH	☐ Yes	☐ No
Adhesive/Tape	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Lidocaine	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No
Latex	☐ Yes	☐ No
Sulfa	☐ Yes	☐ No

Other _____

CONSENT

I certify that the above information is true and correct to the bet of my knowledge. I authorize Dr. D'Altilio, her associates, assistants and/or other qualified medical personnel of her choice to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my podiatric medical condition. I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance.

Patient Signature Print Name Date