WELCOME TO GENTLE FOOT CARE

PATIENT INFORMATION

Date:________________

Patient ____

Address ____

____
City State Zip

Phone #:_____________(Home) _____________(Work)_

Sex: M F Birth date:__________________

Name & Date of Birth of insurer (other than patient):

____

Relationship to patient:_ ____________________

Single Married Widowed Divorced

Patient SS#:______________________________________

Occupation: ______________________________________

Employer: _______________________________________

Emergency Contact:_________________________________

Relationship:________________Phone #:_____________

Whom may we thank for referring you? _____________

INSURANCE

Medicare #:____
Other Insurance Co.:__________________________________
Subscriber Name:____________________________________
Relationship to Patient:_______________________________
Policy #:____________________Group #:______________
Claims Address:______________________________________
____
Insurance Phone #:____________________________________
Co-payment: $_________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________________ and assigned directly to Dr. Van Nguyen all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________________ ________________
Responsible Party Signature Date

MEDICARE AUTHORIZATION

I request that payments of authorized Medicare benefits be made either to me or on my behalf to Dr. Van Nguyen for any services furnished my by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed 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 form, or else where on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assignment cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________________________ ________________
Beneficiary Signature Date

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

____

____

____

Have you ever been to a Podiatrist before?
Yes No
If yes, please list.

Name____________________________

Last visit________________________

Is there any personal or family history of diabetes? Yes No

Your occupation____________________

Cigarette/Tobacco use_______________

Years smoked______________________

Athletic activities in which you participate (Please list and indicate frequency)

____

____

____

Please indicate which foot problems you now have or have had in the past.

Foot ulcer	Yes	No
Toe color: red/blue/pale	Yes	No
Ankle pain	Yes	No
Athelete's Foot	Yes	No
Bunions	Yes	No
Corns and Callouses	Yes	No
Numbness in feet or legs	Yes	No
Cold feet	Yes	No
Foot or leg cramps	Yes	No
Heel Pain	Yes	No
Ingrown Toenails	Yes	No
Plantar Warts	Yes	No
Swelling in Ankles or Feet	Yes	No
Tired Feet	Yes	No

MEDICAL HISTORY

Circle Yes or No to indicate if you have had any of the following

Condition			Condition			Condition		
AIDS/HIV	Yes	No	Diabetes	Yes	No	Multiple Sclerosis	Yes	No
Alcoholism	Yes	No	Ear Problem	Yes	No	Neuropathy	Yes	No
Alzheimer's	Yes	No	Epilepsy/ Seizure	Yes	No	Paralysis	Yes	No
Anemia	Yes	No	Eye Problem	Yes	No	Peripheral Vascular Dis.	Yes	No
Angina	Yes	No	Fainting	Yes	No	Phlebitis	Yes	No
Arthritis	Yes	No	Foot Injury	Yes	No	Psychiatric Care	Yes	No
Artificial Heart Valves			Gout	Yes	No	Radiation Treatment	Yes	No
or Joints	Yes	No	Headaches	Yes	No	Respiratory Disease	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No	Shortness of Breath	Yes	No
Atherosclerosis	Yes	No	Hepatitis or Jaundice	Yes	No	Sinus Problems	Yes	No
Back Problems	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Bleeding Disorder	Yes	No	Immune Disorders	Yes	No	Tuberculosis	Yes	No
Blood Clots (DVT)	Yes	No	Intestinal Problems	Yes	No	Stomach Problems	Yes	No
Cancer	Yes	No	Irregular Heart Rhythm	Yes	No	Varicose Veins	Yes	No
Chemotherapy	Yes	No	Kidney Problems	Yes	No	Venereal Disease	Yes	No
Chest Pain	Yes	No	Liver Disease	Yes	No	Weight Loss, Unexplained	Yes	No
Circulatory Problems	Yes	No	Low Blood Pressure	Yes	No	Others:________________________	Yes	No

Other Medical Problems/History:____
____

Surgeries you have had:____
____

Family Physician:____ Last visit date:____________________________________

Are you now, or have you been, under any other doctor's care for any reason over the past two years? Yes No

If Yes, please explain:____
____
____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins____________________
____
____
____

Pharmacy Name(s)____

Pharmacy Phone(s)____

ALLERGIES

Adhesive/Tape	Iodine
Anticoagulant Therapy	Novocaine
Aspirin	Penicillin
Codeine	Seafood
Demerol	Sulfa
Local Anesthetics	Latex

Other_________________________

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedure as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature____ Date__________________________________