

WELCOME TO THE BEACHWOOD FOOT AND ANKLE CENTER

Ms.: _____
Mrs.: _____
Mr.: _____ DATE OF BIRTH: _____ AGE: _____
ADDRESS: _____ CITY: _____ ZIP: _____
HOME PHONE: _____ SOCIAL SECURITY NO.: _____
EMPLOYER: _____ OCCUPATION : _____
BUSINESS ADDRESS: _____ BUSINESS PHONE: _____
CITY: _____ STATE: _____ ZIP: _____

WHOM MAY WE THANK FOR REFERRING YOU: _____

I certify that the information on this sheet is true and correct to the best of my knowledge. I hereby give Dr. _____ and his or her designee permission to examine and treat my feet. I consent to the photographing of my feet and ankles for medical, scientific, or educational purposes, providing my identity is not revealed by pictures or the descriptive text accompanying them. I also acknowledge the receipt of the Beachwood Foot and Ankle Center *Notice of Privacy Practices*.

Signature: _____ Date: _____

Patient, Parent or Guardian

STATEMENT TO PERMIT PAYMENT OF MEDICAL BENEFITS TO PROVIDER AND PHYSICIAN

I certify that the information given by me in applying for payment under title XVII of the Social Security act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or it's intermediaries or carriers and all private insurance carriers any information needed for this or a related medical claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered medical services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare and/or Private Insurance for payment to me. I request that payment under the medical insurance program be made to the **Beachwood Foot and Ankle Center** on any bills for services furnished me.

Signature of Patient: _____ Date Signed: _____

(PLEASE TURNOVER)

3609 Park East Dr., Suite 406, Beachwood, Ohio 44122

MEDICAL HISTORY

My foot problem is: _____

This problem has existed for: _____ Days/Weeks/Months/Years. Height: _____ Weight: _____

Primary Care Physician: _____ Address: _____

Phone: _____ Date of Last Visit: _____

What medicines do you take regularly? _____

Check any existing allergies:

Novocaine yes no
Penicillin yes no
Adhesive tape yes no
Iodine yes no
Sulfa drugs yes no

Other _____

Family History of:

Arthritis yes no
Bleeding disorders yes no
Cancer yes no
Diabetes yes no
Foot problems yes no
Heart disease yes no
High blood pressure yes no

Surgeries you have had: _____

Hospitalizations other than surgeries: _____

Do you smoke tobacco? yes no Do you drink alcohol? yes no How much? _____

Do you use recreational drugs? yes no Do you exercise regularly? yes no

Do you have children? yes no How many? _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ear Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Medicine or Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foot or Leg Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves or Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling in Ankles, Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis or Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tired Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other Medical Problems: _____

Reviewed by: _____ Date: _____