Welcome to Maryland Podiatry

PATIENT INFORMATION

Today's Date ____________________

SS/HIC/Patient ID # ____________________

Patient Name *(Last)* ____________________

(First / Middle Initial) ______________ _____

Address ____________________

City ____________________

State ______________ Zip ________

E-mail ____________________

Sex ☐ M ☐ F Age ____ Birthdate ________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School ____________________

Employer/School Phone ____________________

Spouse's Name ____________________

Birthdate ____________ SS# ____________

Spouse's Employer ____________________

Whom may we thank for referring you? ____________

Who would you like to refer to us? ____________

PHONE NUMBERS

Home # ____________________

Cell # ____________________

Best time to contact you ____________________

IN CASE OF EMERGENCY, CONTACT

Name ________ Relationship __________

Home # ____________________

Cell # ____________________

Work #

INSURANCE INFORMATION

Who is responsible for this account? ____________________

Relationship to patient ____________________

Insurance Co ____________________

Group # ____________________

Is patient covered by additional insurance ☐ Yes ☐ No

Subscriber's Name ____________________

Birthdate ____________ SS# ____________

Relationship to patient ____________________

Insurance Co ____________________

Group # ____________________

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with the following insurance company*(ies)*

____

and assign directly Maryland Podiatry, Dr. Felicia Armstrong, Dr. Brian Seymore and/or any Doctor &/or company associated with my care in this office 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 authorize the use of my signature on all insurance submissions. The above-named doctor(s) may use my heal care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for related services. This consent will end when my current treatment plan is completed or on year form the date signed below. **I understand all insurance co-pays and deductibles must be paid at the time of service. I understand I will be charged a fee of $25 for all missed appointments with less than 24 hour notice. Any unpaid balances may be turned over to collections if I fail to pay or make payment arrangements. I will be responsible for any fees incurred during the process of collections and/or legal action.**

MEDICARE / MEDIGAP AUTHORIZATION

I Request that payment of authorized Medicare benefits and, if applicable, Medigap benefits be made either to me or on my behalf to Maryland Podiatry, Dr. Felicia Armstrong, Dr. Brian Seymore and/or any Doctor &/or company associated with my care in this office for any services furnished to me by that provider(s). To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services

____

Signature of Beneficiary, Guardian or Personal Representative

____

Please print name of Beneficiary, Guardian or Personal Representative

__________________ __________________

Date *Relationship to Beneficiary*

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated *(included ALL foot, ankle, knee, thigh and/or 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 participated *(Please list all and indicate frequency)*:

____

____

____

____

____

____

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

Problem	Yes	No
Ankle / Foot Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Calluses	☐ Yes	☐ No
Numbness in Feet or Legs	☐ Yes	☐ No
Flat / Tired Feet	☐ Yes	☐ No
Cramps in Foot / Leg	☐ Yes	☐ No
Plantar Fasciitis / Heel Spurs	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Plantar Warts	☐ Yes	☐ No
Swelling in Ankles / Feet	☐ Yes	☐ No

Turn to next page →

MEDICAL HISTORY

Mark "Yes" or "No" below to indicate if you have had ANY of the following:

Condition		Condition		Condition	
Leg / Foot Numbness / Tingling	☐ Yes ☐ No	AIDS / HIV	☐ Yes ☐ No	Hepatitis / Jaundice	☐ Yes ☐ No
Leg / Foot Pain	☐ Yes ☐ No	Allergies to Anesthetics	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Leg / Foot Weakness	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No
Foot / Leg Cramps	☐ Yes ☐ No	Allergies to Medication/Drugs	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Lower Back Pain	☐ Yes ☐ No	Artificial Heart Valves	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No
Arm / Hand Numbness / Tingling	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Phlebitis	☐ Yes ☐ No
Arm / Hand Pain	☐ Yes ☐ No	Bleeding Disorder	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Arm / Hand Weakness	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Rash	☐ Yes ☐ No
Dizziness / Light Headedness	☐ Yes ☐ No	Chest Pain / Angina	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Falls *(With or Without Injury)*	☐ Yes ☐ No	Chronic Diarrhea	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Loss of Balance *(Without Falling)*	☐ Yes ☐ No	Circulatory Problems	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Cold Legs / Feet	☐ Yes ☐ No	Ear Problems	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Blue Legs / Feet	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Swelling in Legs / Ankles / Feet	☐ Yes ☐ No	Eye problems	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Neuropathy	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Tired Feet	☐ Yes ☐ No
Foot / Leg Cramps	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Varicose Veins	☐ Yes ☐ No

List Surgeries you have had ______________________________

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What tests have you had?
☐ Nerve Test (NCV / EMG) ☐ Balance Test (VNG) ☐ Echocardiogram
☐ Blood Flow Test (ABI) ☐ Imaging (X-Ray / MRI) ☐ Heart Test (EKG)

Family / Primary Physician ______________________________ Last Visit Date ______________

Family / Primary Address ______________________________ Phone # ______________

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 medication and vitamins ______________

____

____

____

Pharmacy Name(s) ______________________________

Pharmacy Phone(s) ______________________________

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

☐ Adhesive / Tape ☐ Local Anesthesia
☐ Novocain ☐ Anticoagulant Therapy
☐ Aspirin ☐ Penicillin
☐ Codeine ☐ Seafood
☐ Demerol ☐ Sulfa
☐ Iodine ☐ Other ______________

TREATMENT CONSENT

I hereby consent to give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

______________________________ ______________
Signature of Patient, Parent, Guardian or Personal Representative ***Date***

______________________________ ______________
Signature of Patient, Parent, Guardian or Personal Representative ***Relationship to Patient***