PREMIER PODIATRY
Scott O'Connor, DPM

PREMIER BONE & WELLNESS
Shannon Laesch, APRN

Last Name: _____ First Name: _____ Middle Initial _____

Preferred Name: _____ Former Last Name: _____

Date of Birth: ____/____/____ SSN:_____-_____-_____

Address: _____City/State: _____ Zip: _____

Home Phone: (____)_____Mobile Phone: (____)_____

Preferred Contact Method: (Please check all that apply) ____Email ____Phone____ Text Message

Email Address: _____ Marital Status: S M D W Sep Sex: M F

Spouse name: _____ Spouse Date of Birth: ____/____/_____

Spouse Phone: (_____)_____

Emergency Contact: _____Phone: (____)_____

PREFERRED PHARMACY:_____

Ethnicity: ___White/Not Hispanic ____African American ____Hispanic/Latin American ____Decline

Language: ___English ____Spanish ____Other_____ ____Decline

How did you find out about our office? Relative/Friend____ Yellow pages____ Sign_____ Radio_____

Flyer____ Website_____ Physician Referral (Name): _____ Other:_____

Responsible Party (if other than patient)

Mother: _____ Mailing address_____

Phone: (____)_____ Mother DOB: _____/_____/_____ SS#: _____

Father: _____ Mailing address_____

Phone: (____)_____ Father DOB: _____/_____/_____ SS#: _____

Insurance Information – *please present card for copying*

Primary Insurance: _____ Secondary Insurance:_____

Policy Holder name: _____ Policy Holder DOB: _____/_____/_____

Is this a liability/worker's compensation claim? YES / NO If yes, please provide the following information:

Insurance Co: _____ Claim Number:_____

Insurance Phone Number: (____)_____ Adjustor's Name: _____

Employer: _____ Employer Phone: _____

Date of Injury: _____

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Name: _____ **Today's Date**: ____/____/_____

Age: _____ **Weight**: _____ **Height**: _____ **Shoe Size**: _____

Family Physician: _____ Address: _____

Date Last Seen: _____/_____/_____ Do you have/had Orthotics or Diabetic shoes? _____

Specialist: _____ For what condition? _____

Describe the foot problem you are having today: _____

Right _____ Left_____ For how long? _____

Review of Systems

Do you have **excessive thirst**? Yes / No **Hunger**? Yes / No **Urination**? Yes / No

Any **difficulties healing** cuts or infection? Yes / No Explain: _____

Do you bleed easily or on a **blood thinner**? Yes / No Explain: _____

Do you have a stomach **ulcer**? Yes / No Do you or a family member have a **clotting disorder**? Yes / No

Have you had any problems with (please check all that apply):

____Skin/Hair	____Bleeding	____GI Tract	____Heart Attack
____Bladder/Kidney	____Stroke	____Gout	____Sugar Control
____Neurological	____Liver Disease	____Clotting Disorder	____Numbness
____Extremities	____Heart	____DVT	____Anesthesia
____Eyes/Ears	____Muscle	____Seizure	

If you checked any of the above, please explain further: _____

_____

Past Medical History

□ **See Attached List**

Current Medications – Name, Dosage, Frequency

1._____ 4._____

2._____ 5._____

3._____ 6._____

Any **medical** problems or diseases? _____

Any **allergic** reactions to: **Medications**? Yes / No **Iodine**? Yes / No **Tape**? Yes / No **Latex**? Yes / No

List medication and reactions: _____

_____

Are you **Diabetic**? Yes / No If yes, how is it controlled? _____

Surgical History

Please list any recent surgeries: _____

Have you or a family member had a reaction to anesthesia? Yes/No Explain: _____

Have you had a heart valve or joint replacement? Yes/No Explain: _____

Any other pertinent information condition not previously mentioned? Explain: _____

Social History

Do you drink alcoholic beverages? Yes / No If yes, how many per day? ____ Per Week?_____

Do you smoke? Yes / No If yes, how many per day_____

Have you ever smoked? Yes / No If yes, how many years _____

When did you quit?_____

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I _____ give Pro Podiatry,LLC my permission to:

	YES	NO
1. Leave medical information on answering machine, voicemail, etc.	____	____
2. Leave medical information with family members listed below.	____	____
3. Release medical records to the following individuals listed below	____	____

- **Please list individual by name**
- **Anyone not listed will not be given access to your medical records or information**

1. _____
2. _____
3. _____

NATIONAL Rx DATABASE INFORMATION EXCHANGE

I acknowledge and allow Pharmacy Benefits Manager on behalf of Pro Podiatry,LLC to access information from the national database for prescription and allergy history.

Patient Name (print)

_____

Patient or Authorized Representative (if applicable)

_____

Signature

Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read ***if I so chose***) and understood the notice.

Patient Name (print)

_____

Patient or Authorized Representative:

_____

Signature

Date: _____

Authorization & Financial Agreement

*The undersigned authorizes Pro Podiatry, LLC to release and/or obtain information in the course of treatment regarding medical condition of (patient's name)_____ to the previously named insurance carriers and physicians.
*This consent shall expire 1 year from the date I sign this form. It is my intent that this consent shall cover any an all services from this provider during this time.
*The undersigned also authorizes that their medical benefit payment be made directly to Pro Podiatry, LLC.
*In order to control our cost of billing we request that co-pays be made at the time the services is rendered. All patient balances are expected to be paid upon receipt of bill unless other arrangements are made for payment. If the undersigned fails to pay any remaining balance for services rendered and collection efforts become necessary, the undersigned agrees to be responsible for all collection cost incurred. A collection fee of 33%-50% will be assessed on the account balance at the time the account is placed for regular collection with the agency. In the event legal action is taken, the patient is responsible for payment of all court costs.

Signature: _____ **Date:** _____