PODIATRY ASSOCIATES OF CINCINNATI, INC.

PATIENT INFORMATION • PRINT FIRMLY & CLEARLY

(Circle One) Dr. Mr. Ms. Mrs.

Legal First Name / First Name Used / Middle Initial / Last Name

Spouse's Name

Patient's Home Address Number/Street/City/State/Zip

Preferred Phone

OK to text? ❑ YES ❑ NO

Patient's Employer

Legal/Assigned Sex at Birth

Gender Identity

Preferred Pharmacy / Phone #

Age

Birth Date

Social Security No. ___-___-____

Email

Preferred Language

Race

Ethnicity
❑ Hispanic or Latino
❑ Not Hispanic or Latino

Do you authorize Podiatry Associates of Cincinnati to contact you via email? ❑ YES ❑ NO

INSURANCE POLICY INFORMATION - all fields required.
Primary Insurance Coverage

Insurance Policy Holder Name

Relationship to Patient

Policy Holder Date of Birth

SSN of Policy Holder ___-___-____

Insurance Policy Name

Policy ID#

Group#

SECONDARY INSURANCE COVERAGE

Secondary Insurance Policy Holder Name

Relationship to Patient

Policy Holder Date of Birth

SSN of Policy Holder ___-___-____

Insurance Policy Name

Policy ID#

Group#

MEDICAL INFORMATION

Who is your primary care physician (family physician)

First Name Last Name Last Seen

Who referred you to this office?

❑Physician _____ ❑Patient _____ ❑Other _____

In Case of Emergency

Name Address Phone Number

I give permission to Podiatry Associates of Cincinnati, Inc. to administer treatment for my foot and ankle conditions. I understand that I,or my legal representative, am financially responsible for all services rendered whether covered by insurance or not. I, or my legal representative, am also responsible for all fees incurred if no referral is received for my care.

I, or my legal representative, authorize the release of any medical or other information necessary to process my insurance claims. I, or my legal representative, authorize payment of medical benefits directly to Podiatry Associates of Cincinnati, Inc. and I understand I, or my legal representative, am responsible for any unpaid balance on my account.

Signature _____ Date _____

MEDICAL HISTORY

Describe your current foot problem: _____ How long? _____

Describe onset: _____ Previous Treatments: _____

Are you allergic to any medications (drugs)? ❑ YES ❑ NO If so, please list.

_____

_____

List all medications you are currently taking (please include Aspirin, Tylenol, Vitamins and Birth Control Pills). If you are not currently taking any medications, please write NONE or N/A on line one.

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

Previous Surgeries & Hospitalizations: ( ) NONE

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please check if you have had a history of any of the following:

	YES	NO		YES	NO		YES	NO
Are you currently pregnant?			GI or Rectal Bleeding			Lung Disease		
Anemia			Gout			Night cramps		
Arthritis			Heart disease			Phlebitis		
Asthma			Hepatitis			Psychiatric condition		
Cancer			High Cholesterol			Skin problems		
COPD			Hypertension			Sexually transmitted diseases		
Depression			Kidney disease			Thyroid disease		
Diabetes			Leg pain			Tuberculosis		

Please describe: Other illnesses or diseases which are not listed:

FAMILY HISTORY

Please check if mother or father have a history of any of the following:

	Mother	Father	NO		Mother	Father	NO
Arthritis				Diabetes			
Asthma				Heart disease			
Bunions				Kidney disease			
Cancer				Lung disease			

SOCIAL HISTORY

What is your approximate weight? lbs. Height? ft. in. Shoe size

What is your current occupation? How many hours per day do you stand?

Do you smoke cigarettes? ❑ YES ❑ NO ❑ FORMER If yes, how many packs per day?

Do you drink alcohol? ❑ YES ❑ NO If yes, how many drinks per week?

Do you use recreational drugs? ❑ YES ❑ NO

AUTHORIZATION

I have reviewed the information on the questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status or medications, I will inform the doctor.

Signature _____ Date _____