WELCOME

PATIENT INFORMATION

Date ______
SS/HIC/Patient ID # ______
Patient Name ______
Last Name
______
First Name 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 Address ______
______
Employer/School Phone (____) ______
Spouse's Name ______
Birthdate ______ SS# ______
Spouse's Employer ______
Whom may we thank for referring you? ______

PHONE NUMBERS

Home Phone (____) ______
Cell Phone (____) ______
Best time and place to reach you ______

IN CASE OF EMERGENCY, CONTACT

Name ______
Relationship ______
Home Phone (____) ______
Work Phone (____) ______

INSURANCE

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 ______
Name of Insurance Company(ies)

and assign directly to Dr. Gary M. Greger, DPM, Inc. 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 may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

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 Dr. Gary M. Greger, DPM, Inc.

for any services furnished to me by that provider.
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 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.

Problem	Yes	No
Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Calluses	☐ Yes	☐ No
Cramps or Numbness in Feet or Legs	☐ Yes	☐ No
Flat 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

– O V E R –

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MEDICAL HISTORY

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

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

Surgeries you have had ______
______
______

Hospitalization other than for the surgeries listed ______
______
______

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) ______
Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

☐ Adhesive/Tape
☐ Anticoagulant Therapy
☐ Aspirin
☐ Codeine
☐ Demerol
☐ Iodine
☐ Local Anesthetics
☐ Novocaine
☐ Penicillin
☐ Seafoods
☐ Sulfa
Other ______

TREATMENT CONSENT

I hereby consent and 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

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient