

Patient's Name: _____ SS #: _____

First Name MI Last Name

Date of Birth: _____ Age: _____ Male Female Single Married Widowed Divorced

Street address: _____

City/State/Zip Code: _____ Home phone with area code: _____

Cell phone with area code: _____ Email: _____

Pharmacy name and phone with area code: _____

Patient's employer: _____ Occupation: _____ Work phone with area code: _____

Responsible party: _____ Relationship: Self Spouse Parent Other: _____

Responsible party's address: _____

In case of emergency, name of person to contact: _____

Phone number with area code: _____ Relationship to patient: _____

Is this work-related? Yes No If yes, date of injury? _____ Claim #: _____

Primary Care Physician's name & phone number: _____

How did you hear about our office? _____

If patient is under the age of 18, a legal parent or guardian MUST accompany them for ALL visits. In the event that a parent or guardian is not able to attend the visit, a signed letter from the parent or guardian clearly stating the person authorized to consent to treatment must be brought for each visit.

Authorization to Disclose Health Information

By selecting appointment information this individual has the right to confirm, change, and cancel appointments, as well as know all past appointment history.

Name: _____ Relationship: _____

May disclose (select all that apply): Billing Information Medical Information Appointment Information

Name: _____ Relationship: _____

May disclose (select all that apply): Billing Information Medical Information Appointment Information

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID AND COMPLETE THE REQUESTED INFORMATION

Insurance Company # 1: _____

Phone Number: _____

Primary Insured's Name: _____

Date of Birth: _____

Policy #: _____ Group #: _____

Relationship To Insured: _____

Insurance Company # 2: _____

Phone Number: _____

Primary Insured's Name: _____

Date of Birth: _____

Policy #: _____ Group #: _____

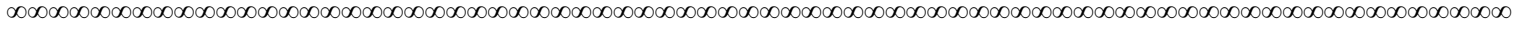
Relationship: _____

- I hereby authorize the payment of medical benefits to **Laser Podiatry Associates, LLC** for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.
- I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce collection of any amounts outstanding.
- I hereby authorize **Laser Podiatry Associates, LLC** to release any medical information necessary to complete and process my insurance claims.
- I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf to Laser Podiatry Associates, LLC for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information to determine these benefits payable for related services.
- I authorize Laser Podiatry Associates, LLC, Jennifer E Mullendore DPM and/or Kenneth Benjamin DPM to treat me and use my personal health information for healthcare operations.

Patient OR Insured Signature (legal guardian signature if patient is a minor)

Date

MEDICAL HISTORY



Reason for Visit:

Shoe Size: _____ Height: _____ Weight: _____ Do you smoke? Yes No Packs/day: _____
Past tobacco use? Yes No Do you drink alcohol? Yes No

Female patients: Are you pregnant? Yes No Nursing? Yes No

- Have you had previous foot or ankle surgery? Yes No
- Have you ever worn custom made arch supports (orthotics)? Yes No
- Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest? Yes No
- Do you experience any pain at rest in your lower leg(s) or feet? Yes No
- Do you experience foot or toe pain that often disturbs your sleep? Yes No
- Are your toes or feet pale, discolored, or bluish? Yes No
- Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)? Yes No
- Has your doctor ever told you that you have diminished or absent pedal (foot) pulses? Yes No
- Have you suffered a severe injury to the leg(s) or feet? Yes No
- Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? Yes No

Allergies: (please check those that apply or provide a list to copy)

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Iodine	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Adhesive Tape	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Codeine	<input type="checkbox"/> Seafood/Shellfish	<input type="checkbox"/> Local Anesthetics	<input type="checkbox"/> Latex	<input type="checkbox"/> Other _____

Current Medications: Prescription and Non-prescription (Or provide a list to copy)

Prior surgery:

- Illnesses: (Please check all that apply)
- | | | | | | |
|------------------------------------|---|--|---|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Numbness in Feet | <input type="checkbox"/> HIV/Aids | |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Blood clots | |

- Family History: (Please check all that apply)
- | | | | | | |
|------------------------------------|---|--|---|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Numbness in Feet | <input type="checkbox"/> HIV/Aids | |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Blood clots | |

I hereby give my permission to the doctor(s) at Laser Podiatry Associates to perform diagnostic, therapeutic and/or operative procedures as may be deemed necessary in diagnosis and/or treatment of my feet and/or ankles.

PATIENT SIGNATURE: _____

DATE: _____