HARTFORD PODIATRY GROUP, LLC PATIENT INTAKE FORM

Welcome to our practice! Please take the time to look over and fill out this form to the best of your ability. If you are unsure of any of the information please ask for assistance. Your cooperation in filling out this form will assist us in making your visit with us as efficient as possible. We thank you for making the HARTFORD PODIATRY GROUP your provider for complete family foot care!

Last Name	First Name	Mi	Age	d.o.b. / /	sex	Phone Numbers: Home: ( ) Work: ( ) Cell: ( )

Street Address city/state/zip	email address	Marital Status single/married/ divorced/widowed/ separated

Policy Holder's Name	Your relationship to policy holder self / spouse / child /	Name and address of person responsible for charges

Primary Insurance Name:	Secondary Insurance Name:	Employer Name and Address

Ethnicity: Please answer the following questions as it pertains to ETHNICITY. These questions are part of a federal requirement that we are required to meet.

If you choose not to answer these questions please indicate here: →→→ [ ] I DECLINE

RACE: [ ] WHITE [ ] BLACK/AFRICAN AMERICAN [ ] AMERICAN INDIAN [ ] ASIAN

[ ] HISPANIC/LATINO/SPANISH ORIGIN [ ] OTHER _____ please specify

Please help us by providing us with information regarding how you were referred to our office. Your answers will help us better serve you!

How did you hear about our office? (please see below)

[ ] Doctors Office (please specify)	[ ] Patient Referral (please specify)	Circle any that apply: Insurance handbook//yellow pages//newspaper ad// Internet search//web site information//hospital referral program OTHER _____

Primary Care Physician:	Pharmacy Name and Address:	If any, former Podiatrist:

Shoe Size	Smoking History? [ ] CURRENT SMOKER [ ] FORMER SMOKER [ ] NEVER SMOKER	Emergency Contact Information: Name: Phone: Relationship:

Do you drink Alcohol [ ] yes [ ] No	Do you use any recreational substances? [ ] yes [ ] no	Do you require any ambulatory aids? [ ]cane [ ] walker [ ] other

Please indicate if there is any personal [self] or [family] history of the following:

CIRCLE which applies

self fam		self fam		self fam	
[s] [f]	Anemia	[s] [f]	Epilepsy	[s] [f]	Liver disease
[s] [f]	Arthritis, Osteo	[s] [f]	Gastric Ulcer	[s] [f]	Lymphatic
[s] [f]	Arthritis, Other	[s] [f]	Gastrointestinal	[s] [f]	Lymphedema
[s] [f]	Arthritis, Rheumatoid	[s] [f]	Genitourinary	[s] [f]	Mitral Valve Prolapse
[s] [f]	Asthma	[s] [f]	GERD	[s] [f]	MRSA History
[s] [f]	Bleeding disorders	[s] [f]	Glaucoma	[s] [f]	Multiple Sclerosis
[s] [f]	Cancer	[s] [f]	Gout	[s] [f]	Neurological/Neuropathy
[s] [f]	Cardiovascular Disease	[s] [f]	Heart Murmur	[s] [f]	Pacemaker
[s] [f]	Circulatory Problems	[s] [f]	Hematologic	[s] [f]	Psychiatric care
[s] [f]	Congenital Heart Lesions	[s] [f]	Hepatitis A	[s] [f]	Seasonal allergies
[s] [f]	Depression	[s] [f]	Hepatitis B	[s] [f]	Skin Disorders
[s] [f]	Diabetes, diet controlled	[s] [f]	Hepatitis C	[s] [f]	Stroke / CVA
[s] [f]	Diabetes, Type I	[s] [f]	HIV/AIDS	[s] [f]	Thyroid disease
[s] [f]	Diabetes, Type II	[s] [f]	Hypertension	[s] [f]	Tuberculosis
[s] [f]	Ear/Nose/Throat	[s] [f]	Kidney disease	[s] [f]	Venereal disease
[s] [f]	Emphysema				

********SURGICAL HISTORY*******

[ ] Appendectomy [ ] breast surgery [ ] cataract surgery [ ] heart bypass surgery [ ] leg bypass surgery
[ ] Hernia repair [ ] cancer related surgery [ ] hip or knee surgery [ ] Spine surgery [ ] gall bladder surgery

[ ] FOOT SURGERY

[ ] other surgical procedures list here

**********MEDICATION ALLERGIES	Type of Reaction	Medication	Type of Reaction
[ ] Antibiotics (list)		[ ] Penicillin	
[ ] Aspirin		[ ] other antibiotics	
[ ] Antiinflamatory Meds (list)			
[ ] Iodine Products		[ ] Sulfa Drugs	
[ ] Latex		[ ] Tape Products	
[ ] Local Anest		[ ] Other	
[ ] Codeine			

******PLEASE CHECK IF YOU HAVE NO KNOWN DRUG ALLERGIES [ ] ******

**********MEDICATIONS********** Please list any medications that you are currently taking:**

[ ] I AM NOT CURRENTLY TAKING ANY MEDICATIONS

*********WHAT IS YOUR MAJOR FOOT COMPLAINT?**

HIPPA

By initialing here [ ] this indicates that I have received/reviewed the HIPPA privacy practices for Hartford Podiatry Grp

AUTHORIZATION FOR TREATMENT

I hereby give permission to the podiatrists of the HARTFORD PODIATRY GROUP and affiliates to administer and perform such procedures as may be deemed necessary for the diagnosis and / or treatment of my foot condition.

Today's Date: [/ /] Signature: X_____

FOR COMPUTER BILLING PURPOSES

PATIENT NAME: _____ DATE: _____

I request that payment of authorized Medicare/Health insurance benefits be made to me or on my behalf to the Hartford Podiatry Group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature:X_____