Patient Enrollment Sheet

PATIENT INFORMATION:

LAST NAME_____FIRST NAME_____ MIDDLE INIT._____

STREET_____ CITY_____ STATE_____ ZIP_____

SSN_____ DOB_____/_____/_____ MALE / FEMALE

HOME PHONE_____ CELL PHONE_____

WORK PHONE_____ E-MAIL ADDRESS _____

EMPLOYER_____YOUR OCCUPATION _____

Primary Care Doctor_____ Primary Doctor Phone _____

How did you hear about our office? ☐ Insurance Directory ☐ Website ☐ Yellow Pages ☐ TV/Radio

☐ Referred by Physician (name) _____ ☐ Referred by friend _____

(do not repeat if same as above)

RESPONSIBLE PARTY: **RELATIONSHIP TO PATIENT_____**

LAST NAME_____FIRST NAME_____ MIDDLE INIT._____

STREET_____ CITY_____ STATE_____ ZIP_____

SSN_____ DOB_____/_____/_____ MALE / FEMALE

HOME PHONE_____ CELL PHONE_____

INSURANCE INFORMATION (COPIES OF FRONT AND BACK OF INSURANCE CARDS)

PRIMARY INSURANCE_____ POLICY NO. _____

SUBSCRIBER_____ DOB ____/_____/_____

SECONDARY INSURANCE_____ POLICY NO. _____

SUBSCRIBER_____ DOB ____/_____/_____

PLEASE READ AND SIGN [I HEARBY GIVE MY PERMISSION TO THE DOCTORS OF MID-WEST PODIATRY & ASSOCIATES, LLC TO ADMINISTER TREATMENT AND TO PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FOOT CONDITION. I HEARBY AUTHROIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO MID-WEST PODIATRY & ASSOCIATES, LLC AND THE RELEASE OF ANY INFORMATION REQUIRED BY THIRD PARTY PAYORS IN CLAIM PROCESSING AND UNDERSTAND THAT I AM FINANICALLY RESPONSIBLE FOR ANY REMAINING BALANCE.]

_____

SIGNATURE (PATIENT/RESPONSIBLE PARTY) DATE

form updated 9/17/2014

Podiatry History (Please Print)

Primary reason for today's visit: Describe any Pain or disability _____

_____

_____

Which side: Left | Right | Both **Rate your pain on a scale of 1 - 10** (1 is no pain)_____

Have you been to a podiatrist before? Yes | No Dr._____ Last Seen _____

Is this a work related injury? Yes | No If yes, has your employer been notified? Yes | No

☐ **Check if No Known Allergies**

Allergy	Yes	Reaction	Allergy	Yes	Reaction
Adhesive/Tape			Novacaine		
Aspirin			Penicillin		
Codeine			Shell Fish		
Iodine			Sulfa Drugs		
Latex			X-Ray Dye		
Other:					

Current Medications ☐ See attached list **OR** List medications and dosage below

Medication	Dosage	Medication	Dosage

Pharmacy:_____ **Address:**_____ **Phone:**_____

Medical History

Check YES below if you are currently being treated for OR have been treated for in the past.

Problem	Yes	Problem	Yes	Problem	Yes
Anxiety		Heart Attack		Psoriasis	
Arthritis		Heart Disease		Psychiatric	
Asthma		Hepatitis (A B C)		Pulmonary Embolism	
Cancer (specify below)		High Blood Pressure		Rheumatoid Arthritis	
Diabetes (type I or II)		High Cholesterol		Seizure Disorders/ Epilepsy	
Emphysema		HIV/AIDS		Stomach Ulcer	
Fibromyalgia		Kidney Disease		Stroke/ TIA	
GERD (acid reflux)		Mitral Valve Prolapse		Thyroid Disorder	
Other:					

Last Name_____ **First Name**_____ **Middle Initial** ____

form updated 2/6/2015

Previous Surgeries

_____

_____

_____

Social History

	Yes	No	Only in Past	**Current Employment Status**	Yes	No
Drink Alcohol				Are you currently employed?		
Use Illegal Drugs				How many hours do you stand at work (daily)?		
Tobacco Use				What type of work do you do?		

Family History

Condition	Yes	Relationship	Condition	Yes	Relationship
Diabetes					
Heart Disease					
Foot Problems					

Review of Systems

Check YES next to any symptoms you are currently experiencing.

Symptom	Yes	**Symptom**	Yes	**Symptom**	Yes
Back Pain		Fatigue		Numbness/Tingling	
Bleeding Problems		Fever		Ringing in the ears	
Chest Pain		Headaches/Migraines		Skin Problems	
Chills		Heartburn/Indigestion		Swelling	
Difficulty Breathing		Joint Discomfort/Pain		Urinary Problems	
Dizziness		Muscle Pain		Excessive Weight Gain	
Eye/Vision Problems		Nose Bleeds		Excessive Weight Loss	
Other:					

Consent for Treatment

I certify that all the above information is true and correct to the best of my knowledge. I give permission to the doctor and his/her assistants to administer and perform such procedures as may be deemed necessary the diagnosis and/or treatment of my podiatric condition(s).

_____ _____

SIgnature of Patient or Authorized Representative Date

To be completed by the physician:

I have reviewed this patient information document

_____ _____

SIgnature of Physician Date

Last Name_____ **First Name**_____ **Middle Initial** ____

form updated 2/6/2015

Patient Name_____ Age _____ Date_____

Demographics

What is your primary language?	□ English □ Decline to answer □ Spanish □Other _____
What is your race?	□ American Indian or Alaska Native □ Decline to answer □ Asian □ Black/African American □ Caucasian □ Native Hawaiian or Other Pacific Islander
What is your ethnicity?	□ Hispanic or Latino □ Decline to answer □ Not Hispanic or Latino

□ History of Diabetes

□ History of High Blood Pressure

□ No History of Diabetes or Hypertension

Smoking Status:

□ **Current Smoker** *Every Day* (Patient smokes every day)

□ **Current Smoker** *Some Day* (Patient smokes infrequently but has smoked more than 100 cigarettes)

□ **Current Smoker** *Unknown* (Patient is unable or refuses to quantify how much they smoke)

□ **Former Smoker** (Patient was a "Current Smoker" in the past, but no longer smokes)

□ **Never a Smoker** (Patient has smoked less than the equivalent of 100 cigarettes in his/her life)

□ **Unknown if ever smoked** (patient is unable or refuses to answer)

For Office Use Only

Height _____ inches **Weight** _____lbs **BMI**_____

Blood Pressure _____/_____mm/Hg **Pulse**_____ bpm

Temp _____° F **Shoe Size**_____

HbA1c (for diabetics only) **_____**

Office Signature_____

form updated 9/17/2014

Mid-West Podiatry & Associates, L.L.C.

www.midwestpodiatry.com

Physicians & Surgeons of the Foot and Ankle

Jeffrey S. Brooks, DPM
H. John Visser, DPM
Robert K. Duddy, DPM
Kurt W. Kaufman, DPM
Karl B. Collins, DPM
Carmina Quiroga, DPM
Brian Broadhead, DPM

Board certified by American Board of Podiatric Surgery

Shirley C. Visser, DPM
Jared J. Visser, DPM

Brian Bourbon, CPED
Tyler Visser, CPED

In order to make communications concerning appointments, treatment and billing matters easier, law requires your consent to release personal and health information.
Please list specific names of family members and/or friends that have your permission to obtain information from this office regarding your care and personal information.

NAME	**RELATIONSHIP**
_____	_____
_____	_____
_____	_____
_____	_____

I give my permission to leave a message on my:

_____ Home answering machine _____ Work voicemail

_____ Cell phone _____ E-mail

Patient Name: _____

Signature: _____

Date: _____

*Signature of patient representative if patient is a minor or an adult unable to sign.

*Relationship to Patient:_____

11709 Old Ballas Rd., Suite 201, Creve Coeur, MO 63141, 314-432-1903 • 141 E. Madison, Suite 100, Kirkwood, MO 63122, 314-821-8855 • 851 E. 5th Street, Suite 320, Washington, MO 63090, 636-239-1633 • 1101 Weber Road, Suite 301, Farmington, MO 63640, 573-756-8986

1004 Park Drive, Ste. Genevieve, MO 63670, 1-800-562-9714 • #70 Jungerman Circle, Ste. 201, St. Peters, MO 63376, 636-916-9525 • 2900 Lemay Ferry Rd., Ste. 204, St. Louis, MO 63125, 314-894-4684

Mid-West Podiatry & Associates, LLC

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's updated Notice of Privacy Practices.

_____
Signature of patient or parent/legal guardian/legally responsible person

_____
Description of relationship to the patient

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual/Representative refused to sign the form
__ An emergency situation prevented us from obtaining acknowledgement
__ Other (Please Specify)

_____

_____

_____