



PATIENT INFORMATION

Date: _____ Soc. Sec. #: _____ Birthdate: _____
Last Name: _____ First Name: _____ Middle Initial: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Sex: M F Minor Single Married Divorced Widowed Separated
Employer: _____ Business Phone: _____
Occupation: _____ Who may we thank for referring you? _____
In case of emergency, who should we contact? _____ Phone: _____

PRIMARY INSURANCE

RESPONSIBLE PARTY

Last Name: _____ First Name: _____ Middle Initial: _____
Relationship to Patient: _____ Birthdate: _____ Soc. Sec #: _____
Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____
Responsible Party Employed By: _____ Business Phone: _____
Insurance Company: _____
Insurance Company Address: _____
Subscriber I.D. #: _____ Group #: _____

ADDITIONAL INSURANCE

RESPONSIBLE PARTY

Last Name: _____ First Name: _____ Middle Initial: _____
Relationship to Patient: _____ Birthdate: _____ Soc. Sec #: _____
Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____
Responsible Party Employed By: _____ Business Phone: _____
Insurance Company: _____
Insurance Company Address: _____
Subscriber I.D. #: _____ Group #: _____

PHYSICIAN INFORMATION

Primary Physician: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____

Assignment and Release

I hereby authorize payment directly to Feet For Life Centers of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependants.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ Date: _____

Medical History

Patient Name: _____ Date: _____
 Primary Care Physician: _____ Date Last Seen: _____
 Did your doctor request you to be seen today? Yes No
 Former Podiatrist: _____ Date Last Seen: _____
 Reason for seeing doctor today is: _____

Is there a chance you may be pregnant? Yes No / How many months? _____

Indicate which of your immediate relatives have had any of the following:

Cancer: _____ Diabetes: _____
 Heart Trouble: _____ High Blood Pressure: _____
 Kidney Disease: _____ Mental/Emotional: _____
 Stroke: _____ Arthritis: _____

Please indicate if you have had any of the following problems:

Yes	No	Problem		Yes	No	Problem
		Recent Weight Loss				Swelling In Feet
		Headaches				Arthritis
		Vision Trouble				Kidney Disease
		Allergies/Hay Fever				Gout
		Trouble Hearing				Bleeding Tendency
		Asthma				Scarring Tendency
		Thyroid				Joint Pain Stiffness
		Diabetes				Numbness in Feet/Legs
		Skin				Cramping in Feet/Legs
		Anemia				Low Back Pain
		Heart				Psychiatric
		M.V. Prolapse/Heart Murmur				Fainting/Convulsion
		Circulation				Strokes
		High Blood Pressure				Stomach Trouble
		Chest Pain				HIV Positive
		Shortness of Breath				Do You Smoke? How Much? _____
		Liver Disease/Gallbladder Jaundice/Hepatitis				Do You Take Drugs? _____ Legal _____ Illegal
		Allergic To Any Medications? Please List: _____ _____ _____ _____				Do you drink alcohol? How Much? _____
						Sickle Cell Disease If Yes: _____ trait _____ disease

MEDICATIONS LIST

Please list **ALL** medications you are currently taking



	MEDICATION	DOSAGE	ADMINISTRATION METHOD
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			

Symptoms Information

How would you describe your pain to the best of your ability? (check all that apply)

Sharp Dull Aching Superficial Deep
 Burning Shooting Throbbing Tingling Other _____

What makes the pain worse? (check all that apply)

Running Walking Standing Certain Shoes
 Elevation Touching/Rubbing Resting Other _____

How long have you had the pain? (Be specific – i.e.: 4weeks)

Days Weeks Months Years

How long does the pain last, when you have it?

Seconds Minutes Hours Chronic

Have you had **any** trauma? If yes, please explain.

No Yes: _____

 Date of trauma: _____

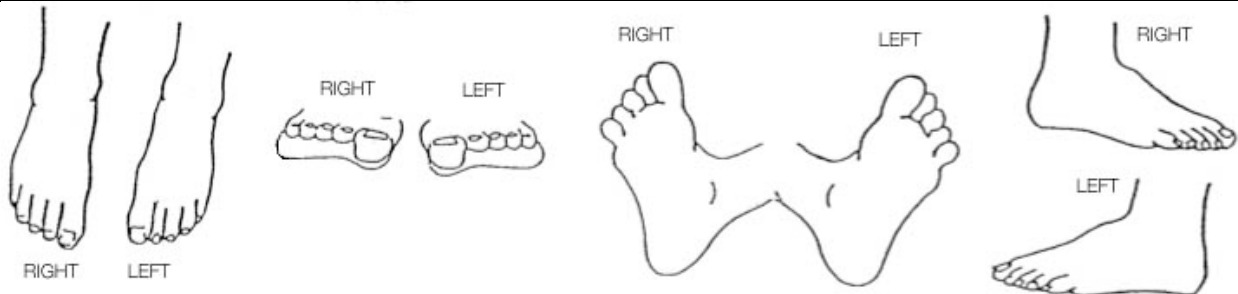
Have you tried treatment in the past? If yes, please explain and include dates.

No Yes: _____

 Previous Doctors: _____

Is there a family history of such a problem?

Yes No



MARK PAINFUL AREAS WITH AN "X"



PHOTO RELEASE

FOR VALUABLE CONSIDERATION, including the agreement to produce a broadcast commercial for "Feet For Life Centers", I hereby irrevocably grant Dr. Michael Horwitz, Feet For Life Centers, Counterhound Production LLC, its licenses, agents, successors and assigns, the right (but not the obligation), in perpetuity throughout the world, in all media, known or hereafter known, to use (in any manner it deems appropriate, and without limitation) in and in connection with the broadcast commercial, by whatever means exhibited, advertised and exploited: my appearance in the video, still photography of me, recordings of my voice taken or made of me by it, and my actual or fictitious name.

On my own behalf, and on behalf of my heirs, next of kin, executors, administrators, successors and assigns, I hereby release Dr. Michael Horwitz, Feet For Life Centers, Counterhound Productions LLC, its agents, licenses, successors and assigns, from any and all claims, liabilities and damages arising out of the rights granted hereunder, or the exercise thereof.

Date _____ Patient name _____
(please print)

Signature _____

I am the parent or legal guardian of _____. I hereby irrevocably consent to the foregoing grant and agreement.

Date _____ Signature _____

Witness _____



**ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICE
H.I.P.A.A**

I hereby acknowledge that I am familiar with the Notice of Privacy Practices and have had the opportunity to read if I so choose and have understand the Notice.

Patient Name (please print)

Parent or Authorized Representative (if applicable)

Signature

Date

RELEASE OF INFORMATION AUTHORIZATION
(not required)

I hereby authorize _____ to obtain information regarding my healthcare with Feet For Life Podiatry Centers.

Signature

Date