Midwest Podiatry Group

Drs. Donald Sheller ~ Christine Kancius

Welcome to our office!

Name: last_____first_____ mi_____

Address:_____city_____st_____zip_____

Home Phone_____Cell_____Work_____

Birthdate_____ Sex: M F Height_____ Weight_____Shoe Size _____

Occupation_____ Employer_____

Emergency Contact_____Phone #_____

Marital Status: S___M___W___D___ Email Address: _____

Do you have health insurance? Yes___No___ If yes, we need a copy of your insurance card for your records.

Whose policy is it?_____

Guarantor Name:_____ Relationship to patient_____

Address_____ Phone_____

Guarantor's birthdate_____ Employer_____

All unpaid balances and/or denied claims are your responsibility

Name of Primary Insurance:_____

Name of Secondary Insurance:_____

Medical Dr's Name_____Date of last visit_____

Hospital Preference_____ Pharmacy Preference_____

Who referred you to our office?_____

What is your feet or ankle problem?_____

How long have you had this problem?_____treated before?_____
by whom? _____

Please list any previous foot problems / injuries _____

Is this a work related injury? No____ Yes_____

Medical Information

Past Medical History

Have you ever had one of the following?

❑ Measles	❑ Cataract	❑ High Blood Pressure	❑ Seizure
❑ Mumps	❑ Cellulitis	❑ Low Blood Pressure	❑ Sexually Transmitted Disease
❑ Chickenpox	❑ Circulatory Disorders	❑ Hearing Loss	❑ Skin Problems
❑ Rheumatic Fever	❑ COPD/Breathing Problems	❑ Hepatitis ____	❑ Stroke
❑ AIDS or HIV +	❑ Depression	❑ Kidney Disease	❑ Swelling of Feet/Ankles
❑ Anemia	❑ Diabetes	❑ Liver Disease	❑ Tuberculosis
❑ Arthritis	❑ Digestion Problems	❑ Migraine Headaches	❑ Thyroid Disease
❑ Asthma	❑ Dizziness	❑ Numbness/Tingling	❑ Transplant
❑ Balance Problems	❑ Ear/Nose/Throat Problems	❑ Pacemaker	❑ Ulcer Stomach/Skin
❑ Bladder Problems	❑ Epilepsy	❑ Pneumonia	❑ Varicose Veins
❑ Blood/Plasma Transfustions	❑ Fainting	❑ Polio	❑ Vision Problems
❑ Bowel Problems	❑ Fevers over 103°	❑ Prolonged Bleeding	❑ Other_____
❑ Cancer	❑ Heart Disease	❑ Psychological Problems	

Have you received the following: flu vaccine_____; pneumonia vaccine_____ / yr_____

Previous Hospitalizations/Surgeries/Serious Illness (and When?) _____

_____

_____

What medication &/or vitamins are you taking now and what dose?_____

_____

_____

(Women) Are you pregnant ❑ Yes ❑ No Are you taking Birth Control Pills? ❑ Yes ❑ No

Are you under any care of a physician? ❑ Yes ❑ No If yes, for what reason(s)?_____

Social History

Do you live alone? ❑ Yes ❑ No For how long?_____

Do you have children? ❑ Yes ❑ No If yes, how many?_____

Do you exercise? ❑ Yes ❑ No If yes, how often?_____What kind of exercise?_____

Are you on a special diet? ❑ Yes ❑ No If yes, what kind?_____

Do you smoke? ❑ Yes ❑ No If yes, how many packs per day? #_____ for #_____years

If former smoker, when did you quit? _____ How many packs had you smoked? #_____ for #_____years

Do you drink alcohol? ❑ Yes ❑ No How much_____Daily_____Weekly_____Monthly_____Yearly

Do you have a history of substance abuse? ❑ Yes ❑ No What substance(s)?_____

Medical Information

Family History

Has anyone in your family ever been diagnosed with the following? Name the relationship next to the condition in the space provided. (parents, brothers, sisters, children)

❑ Arthritis_____ ❑ Diabetes_____ ❑ Hypertension_____

❑ Cancer_____ ❑ Foot Problems_____ ❑ Neurological Problems_____

❑ Circulatory Disease_____ ❑ Heart Disease_____ ❑ Skin Disease_____

Additional space, if necessary _____

_____

Review of Systems

Please indicate any personal history below, Cirlce:

Cardiovascular
Chest pain or angina.....No Yes
Swelling of feet, ankle or hands....No Yes

Constitutional Symptoms
Good general health lately.....No Yes
Recent weight change.....No Yes
Fever.....No Yes
Fatigue.....No Yes

Ears/Nose/Mouth/Throat
Hearing Loss.....No Yes
Earaches.....No Yes
Ringing in ears.....No Yes
Sinus problem.....No Yes
Nose bleeds.....No Yes
Swollen glands in neck.....No Yes

Endocrine
Excessive thirst or urination.....No Yes
Heat or cold intolerance.....No Yes
Skin becoming drier.....No Yes

Eyes
Wear glasses/contact lenses.....No Yes
Blurred or double vision.....No Yes

Gastrointestinal
Loss of appetite.....No Yes
Nausea or vomiting.....No Yes
Diarrhea.....No Yes
Constipation.....No Yes
Blood in stool.....No Yes
Abdominal pain.....No Yes

Genitourinary
Frequent urination.....No Yes
Buring or painful urnination.....No Yes
Blood in urine.....No Yes
Incontinence of dribbling.....No Yes

Hematologic/Lymphatic
Slow to heal after cuts.....No Yes
Bleeding or bruising tendency.....No Yes
Phiabitic.....No Yes
Past transfusion.....No Yes

Integumentary (skin, breast)
Rash or itching.....No Yes
Change in skin color.....No Yes
Change in hair or nails.....No Yes

Musculoskeletal
Joint Pain.....No Yes
Joint Stiffness or swelling.....No Yes
Muscle pain or cramps.....No Yes
Back pain.....No Yes
Cold extremities.....No Yes
Difficulty in walking.....No Yes

Neurological
Headaches.....No Yes
Lightheaded or dizzy.....No Yes
Convulsions or seizures.....No Yes
Numbness or tingling sensations..No Yes
Tremors.....No Yes
Paralysis or weakness.....No Yes

Psychiatric
Memory loss or confusion.....No Yes
Nervousness.....No Yes
Depression.....No Yes
Insomnia.....No Yes

Respiratory
Chronic or frequent coughs.....No Yes
Shortness of breath.....No Yes

Allergies:

Do you have a history of skin reaction or other adverse reaction to:

❑ Anethetics ❑ Codeine ❑ IV Dye ❑ Silver
❑ Animals/Dander ❑ Environmental Substances ❑ Pain Medication ❑ Sulfa
❑ Antibiotic ❑ Foods ❑ Penicillin ❑ Tape
❑ Aspirin ❑ Iodine ❑ Seasonal Allergies ❑ Tetnus
❑ Latex

Specify above and list any others: _____

To the best of my knowledge, the above information that I have submitted is correct. I understand that giving incorrect information can be dangerous to my health. It is my responsibility to inform the doctors' office of any changes in my medical status. I, hereby, give my permission to the Doctors of Midwest Podiatry Group to diagnosis and administer treatment of my foot condition.

Signature_____ Date_____

ADVANCE CARE PLAN

It is good to think about future health care needs and to discuss this with others. If a time comes when you are unable to make your own decisions, the law assures that you will be represented by closest relative, your primary care giver, or someone appointed by you. You can help this person by telling them what would be important to you in this stage of your life. This document is our record of who you want this person to be.

My Name: _____

Date of Birth: _____

Patient declined to provide information:

Signature: _____ Date: _____

If I am unable to make my decisions about my health care, the person who is to represent me is: _____

Contact details for this person are:

Address: _____

Phone: _____

Signed: _____

Witness: _____

Date: _____

Midwest Podiatry Group

PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by Midwest Podiatry Group and its employees or designees. I authorize the physical health care services deemed necessary or advisable by my caregivers to address my needs. _____
(initial)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION.
I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the Practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Practice may release objective clinical information related to my diagnosis and treatment, which may be requested by my insurance company or its designated agent. _____
(initial)

ASSIGNMENT OF INSURANCE BENEFITS / PAYMENT GUARANTEE / COLLECTIONFEE.
I authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to the Practice for any covered or non-covered services, as defined by my insurance. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney's fees. _____
(initial)

PRIVACY POLICY. I acknowledge having received the Practice's "Notice of Privacy Policies". My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the Practice has already made disclosures with my prior consent. _____
(initial)

_____ _____ _____
Patient or Authorized Person Signature Relationship Date