Grossman Podiatry Center
family footcare since 1932

# Patient Information Form

**Social Security #**: _____ - _____ - _____ **Birthdate:** _____

**Last Name:** _____ **First Name:** _____ **M.I.:** _____

If patient is a minor, please list **parent or guardian name**: _____

**Address:** _____ **PO Box#:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Cell Phone #:** _____ (for reminders)

**I would like to receive a call / a text as a reminder. (Circle One)**

**Primary Care Physician/ Practice Name:** _____

**Your Email Address:** _____@_____._____
**(please print neatly, use one checked regularly, used for sending statements when possible)**

**Pharmacy Name & Location Used:** _____

**Heard of the practice:** ☐ Friend/Family ☐ Internet ☐ Phonebook ☐ Doctor/Insur. ☐ Sign ☐ Prev. Pt.
☐ Other _____

**Race/Ethnicity Information:** (circle best response) Asian Black/African American Hispanic/Latino Non-Hispanic Latino Native American Pacific Islander White Unknown More than one race

# Insurance Information

**Type of Insurance:** _____

**ID#:** _____ **Group #:** _____

**Secondary Information (if applicable)**: _____

**How are you related to the person who carries your insurance?**

**Please circle one:** Self/Husband/Wife/Child/Parent/Other

**Subscriber/Guarantor Information:**

**Social Security #**: _____ - _____ - _____ **Birthdate:** _____

**Last Name:** _____ **First Name:** _____ **M.I.:** _____

**Address:** (if different than above) _____ **PO Box#:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Phone #:** _____

Name: _____

***Please fill form to the best of your ability. Thank you!***

**Allergies:** Please list all allergies including medication, environmental, tape, latex or others and the reaction(s) it(they) cause(s). ☐ **I have no allergies that I am aware of.**

| Substance: | Reaction: |
|---|---|
| | |
| | |
| | |

**Medications:** (Please include name, dose and how taken); include OTC or others for inflammation

☐ **I do not take any medications.** ☐ **I have a separate list of my medications.**

| Name of Medication: | Dose: | How taken: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Family History:**

| | Age: | If deceased, cause | Diabetes | Cancer | Heart Disease | Stroke | High Blood Pressure | Other |
|---|---|---|---|---|---|---|---|---|
| Father | | Alive/Deceased | | | | | | |
| Mother | | Alive/Deceased | | | | | | |
| Sibling B or S | | Alive/Deceased | | | | | | |
| Sibling B or S | | Alive/Deceased | | | | | | |

**Social History:**

Occupation: _____

Have you ever smoked? **Y or N** Do you smoke or use chew? If so, how many packs/cigs per day? _____

Alcohol: How many drinks per day/week/month? _____

**Patient Medical History:**

| | Y | N | | Y | N | | Y | N | | Y | N |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Measles | | | Anemia | | | Back Trouble | | | Stomach Ulcer | | |
| Mumps | | | Bladder Infections | | | ↑ Blood Pressure | | | Kidney Disease | | |
| Chickenpox | | | Epilepsy | | | High Cholesterol | | | Thyroid Disease | | |
| Whooping Cough | | | Migraine Headaches | | | Asthma | | | Bleeding Tendency | | |
| Scarlet Fever | | | Tuberculosis | | | Hives or Eczema | | | Arthritis | | |
| Diphtheria | | | Diabetes | | | AIDS or HIV+ | | | Liver Disease | | |
| Smallpox | | | Cancer | | | Infectious Mono | | | Down's Syndrome | | |
| Pneumonia | | | Polio | | | Bronchitis | | | Stroke | | |
| Rheumatic Fever | | | Glaucoma | | | Hepatitis | | | Depression | | |
| Heart Disease | | | Blood Transfusion | | | COPD | | | Parkinson's | | |
| Crohn's Disease | | | Osteoporosis | | | Anxiety | | | | | |

Previous Hospitalizations/Surgeries/Foot Surgeries /Serious Illnesses:

_____

_____

_____

**Foot Problem History:**

**Have you ever had any of the following foot problems in the past?**

| Problem: | Y | N | L/R Foot | Treatment: |
|---|---|---|---|---|
| Bunions | | | | |
| Hammertoes | | | | |
| Heel Spurs/Plantar Fasciitis | | | | |
| Corns | | | | |
| Calluses | | | | |
| Ingrown Toenails | | | | |
| Fungus Toenails | | | | |
| Athlete's Foot | | | | |
| Warts | | | | |
| Flat Feet | | | | |
| High Arches | | | | |
| Pinched Nerves/Neuroma | | | | |
| Gout | | | | |
| Edema | | | | |

**History of Present Illness:**

Check off the foot problem(s) you are having today.

⊙ Ingrowing Nail(s)
⊙ Wart
⊙ Callus/Corn
⊙ Discolored/Fungal Nail(s)
⊙ Rash
⊙ Pain; Heel/Foot, Left/Right/Both
⊙ Diabetic Foot Care
⊙ Other _____

If pain, where?
_____

If pain, how long? _____ days/weeks/months/years.

Pain Scale: (1 to 10, 10 being the worst) _____

Describe the pain:
_____
_____
_____

Cause of the problem: (injury, deformity, unknown, other)
_____
_____
_____

Aggravated by: (walking, standing, shoes, physical activity, other)
_____
_____
_____
Comments:

**Authorization & Release:**

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the podiatry staff to perform the necessary services I may need. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable directly to the doctor.**

X_____
Signature of Patient (or parent/guardian) Date

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## Important Office Policies

This office strives to have a clear understanding of the following policies. **Please initial by statements**.

(initial)_____ 1. I agree to let this office know when I will not be able to make an appointment. I understand that I may be charged $25 if I do not notify the office. I understand that I will not be able to reschedule with this office if I chronically miss appointments.

(initial)____ 2. I agree to pay my co-pay the day of appointment as per my insurance company regardless of the amount. I understand that I may be asked to pay balances due to this office prior to being seen. I understand that if I have a delinquent balance I will be unable to reschedule until it is paid.

(initial)_____ 3. I understand that I am ultimately financially responsible for my visit with this office today. I understand that this office cannot know with certainty until it files a claim on my behalf to my insurance company whether the visit will be covered and what amount may be due.

(initial)_____ 4. I understand that this office will follow HIPPA guidelines and keep my information safe and secure while using it to do their jobs on my behalf. If I need more info regarding HIPPA, I need only ask.

I agree to the above policies as indicated by my initials.

Print Name: _____ Date: _____

Signature: _____ lsg 10/2025