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:** _____

Primary 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: _____ ***(Used ONLY for office patient portal)***

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 04/2021