Let's Get Acquainted

Name: _____ **SSN:** _____

Address: _____ **Zip Code**: _____

Home#: _____ **Work#**: _____ **Cell#**:_____

D.O.B: _____ **Gender:** Male/Female **Marital Status**: _____

Race:

___ American Indian/Alaska Native

___ Asian ___ Other Pacific Islander

___ Black or African American

___ Native Hawaiian ___ More than one race

___ Caucasian ___ Refused to report

Ethnicity:

___ Hispanic or Latino

___ Not-Hispanic or Latino

___ refused to report

Preferred Language:

___ English

___ Spanish

___ other

Email: _____

Health Insurance

Primary Insurance: _____ **Member ID#:** _____
Policy Holder:
Name: _____ **D.O.B:** _____ **SSN:** _____
Relationship to Patient: _____
Secondary Insurance: _____ **Member ID#:** _____
Policy Holder:
Name: _____ **D.O.B:** _____ **SSN:** _____
Relationship to Patient: _____
Employer (name & address): _____
_____
Auto Accident? ___Yes ___ No **Date of Accident:** _____
Worker's Compensation? ___ Yes ___ No **Date of Injury:** _____
Emergency Contact: _____ **Phone Number:** _____
Relationship to Patient: _____

Primary Care Physician:

Name: _____ **Phone Number:** _____

Pharmacy:

Name: _____ **Phone Number:** _____

Location/Intersection: _____

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Medical History Form

Please fill out the information below to the best of your ability

Patient Name: _____ **D.O.B:** _____

Height: _____ **Weight:** _____ **Shoe Size:** _____

Describe your foot problem: _____

Past Medical History:

Have you ever been treated for any of the following? (Please check all pertinent boxes)

___ AIDS/HIV
___ Diabetes
___ High/Low Blood Pressure
___ Anemia/Blood Disorders
___ Bleeding Tendency
___ Stroke
___ Arthritis
___ Epilepsy/Seizures
___ Migraines/ Headaches
___ Thyroid Disorder
___ Asthma
___ Eye Disorders
___Tuberculosis
___ back pain/disorders
___ Heart Disease
___ Gastrointestinal Disorders
___ Neurological Disorders
___Vascular Disease
___ Skin Disorders
___ Kidney Ailments
___ Liver Ailments
___ Cancer
___ Rheumatic Fever
___ High Cholesterol
___ Poor circulation
___ Gout
___ Ear/Nose/Throat
___ Leg Cramps
___ Blood Transfusions
___ Emphysema/COPD
___ History of Fracture
___ Hepatitis
___ Other
_____

Current Medications:

*Drug Name	*Dosage	Frequency

Allergies:

*Medication	Reaction	*Non-Medication	Reaction

Past Surgical History: (Please list type of surgery and date)

_____

_____

Family History: (list any health conditions)

Father: _____

Mother: _____

Siblings: _____

Social History:

Use of Tobacco	**Use of Alcohol**
Never	Never
Previously/quit	Socially
Currently	Moderately
Packs per Day ___	Daily

Let's Get Acquainted

Have you had an injuries or operations on your feet and/or legs? ___ Yes ___ No
If yes, please specify: _____
Is there any other information about your health that you feel we should know? ___ Yes ___ No
If yes, please specify: _____
Woman Only:
Is there a possibility that you are pregnant at this time? ___ Yes ___ No
Last Menstrual Cycle? _____
Are you currently nursing your child? ___ Yes ___ No

- I authorize Dr. Gregory McNamara to administer treatment or perform any minor operative procedures as may be necessary in the diagnosis and/or treatment of my foot problem.
- I authorized Dr. Gregory McNamara to release any information acquired in the course of my examination or treatment only for the purpose of filing medical insurance claims. I also authorize insurance payment directly to Dr. McNamara for the surgical and/or medical benefits that may be payable to me for these services.
- I understand that I **MAY** be responsible for any charges NOT covered through my insurance policy.

I understand that:

1. There will be a minimum fee of $15.00 for each disability and/or insurance form completed by the office.
2. Copies of x-rays may be obtained for a minimal fee with a 48 hour notice (originals cannot be released without the doctor's consent).
3. Copies of patient's records are released only with doctor's approval.
4. If I do not have medical insurance, I will be expected to sign a statement stating that charges are my total responsibility and due at the time of service.
5. All co-payments are to be paid at the time of service. If co-payments are not paid on the day of the visit, I **WILL** be responsible for a $10.00 billing fee in addition to the copay amount. All returned checks are subject to $35.00 return check fee. After the third statement the account is turned over to collections and a 2% interest will be applied every month until paid in full.
6. All appointments not cancelled 24 hours prior to appointment time will be subjected to a $25.00 charge.

X _____ Date Signed: _____
Signature of Patient (or Legal Representative)

Relationship to Patient: _____

Witness: _____ Date: _____