

PATIENT DATA/EMERGENCY NUMBERS

DATE / /

STAFF USE

Name: _____		Your type of job activity/occupation: _____		Acct# _____	
		Shoe Size: _____	Weight: _____	Height: _____	Reviewed: _____
				<input type="checkbox"/> NEW <input type="checkbox"/> UPDATE	
In case of emergency, please first call:		Friend or Relative not living with you:		Please provide your preferred Pharmacy:	
Day ()		Day ()		Street / City: _____	
Evening: ()		Evening: ()		Phone: ()	

PATIENT MEDICAL HISTORY

Do you have or ever been treated for:

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nerve disorder | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> None of these |

Additional not listed above:

Are you currently taken any medication. Yes No

Medication	For what reason?	How long
_____	_____	_____
_____	_____	_____

Allergies: Do you have a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:

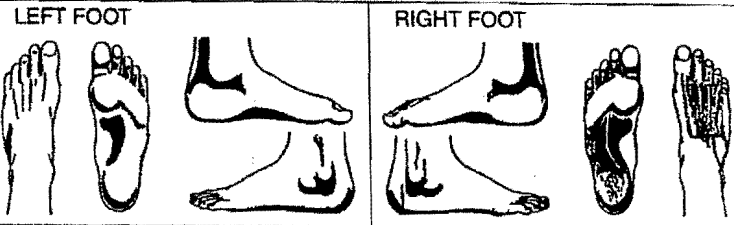
<i>(Check box that applies)</i>	Yes	No	Don't know
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what happens: _____			
Morphine, Codeine, Demerol or other narcotic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what happens: _____			
Novocaine or other anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what happens: _____			
Aspirin, Empirin or other pain remedies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what happens: _____			
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what happens: _____			
Adhesive tape	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what happens: _____			
Shrimp, Iodine, or Merthiolate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what happens: _____			
Any other drugs, medication or treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, List: _____			

Do you smoke now? No Yes Packs/day _____ Years _____

Did you ever smoke? No Yes Packs/day _____ Years _____

PATIENT CURRENT MEDICAL PROBLEMS

Describe up to 2 main problems in greater detail below & mark on the diagram below the areas where you have each problem using numbers 1 to 2 to identify.



1. Please mark the location of your first problem or pain on the diagrams above with a number 1. Describe your problem below and its cause if you know. Please describe associated pain.

My first problem is... On Left foot On Right foot On Both foot

_____ Is this problem work related? Yes No

Date of injury: / / Date of report to employer: / /

My Pain/Discomfort began: _____

It occurs when: _____

Previous medical treatment(s) or home remedies: _____

2. Please mark the location of your second problem or pain on the diagrams above with a number 2. Describe your problem below and its cause if you know. Please describe associated pain below

My first problem is... On Left foot On Right foot On Both foot

_____ Is this problem work related? Yes No

Date of injury: / / Date of report to employer: / /

My Pain/Discomfort began: _____

It occurs when: _____

Previous medical treatment(s) or home remedies: _____

Additional Information: _____

Patient Family Physician Referred by Yes No

PATIENT INFORMATION

Thank you for choosing Sowell Podiatry! In order to serve you properly, we need the following information. **Please print.** All information will be kept confidential.

Date _____ Patient Name _____ Home Phone _____

SS # _____ Male Female Birthdate _____

Address _____ City _____ State _____ Zip _____

Circle appropriate status: Minor Single Married Divorced Widowed Separated

Patient's or parent/guardian employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work Phone _____

If patient is a student, name of school/college _____ City _____ State _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone _____

In case of an emergency, if the patient is of school age 15+, it is all right to treat in my absence.

X _____
Parent or guardian signature _____ Date _____

Responsible Party

Name of person responsible for this account _____ Relationship _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Employer _____

Work Phone _____ Is this person currently a patient in our office? Yes No

Insurance Information

Name of insured _____ Relationship _____

Birthdate _____ SS# _____ Work phone _____

Name of employer _____ Date employed _____

Address of employer _____ City _____ State _____ Zip _____

Insurance company _____ Group# _____ Deductible amount _____

Do you have additional insurance? Yes No If yes, complete the following:

Name of insured _____ Relationship to patient _____

Birthdate _____ SS# _____ Work Phone _____

Name of employer _____ Date employed _____

Address of employer _____ City _____ State _____ Zip _____

Insurance company _____ Group# _____ Deductible amount _____

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 to me directly to the doctor.

X _____
Signature of patient or parent/guardian if minor _____ Date _____

**MODEL PATIENT ACKNOWLEDGMENT OF RECEIPT OF
SOWELL PODIATRY NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge receiving a copy of SOWELL PODIATRY Notice of Privacy Practices, dated _____.

PATIENT NAME

PATIENT'S DOB

PATIENT'S SOCIAL SECURITY #

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE*

DATE

* If signed by a Personal Representative, the following information must also be included:

NAME OF PERSONAL REPRESENTATIVE

DESCRIPTION OF THE PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF THE PATIENT