

**SUPERIOR PODIATRY – NEW PATIENT HISTORY FORM – PLEASE PRINT**

**admin@superiorpodiatry.com**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home # ( ) \_\_\_\_\_ Cell # ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Relationship: \_\_\_\_\_  
E-Mail: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_  
Fax Number: ( ) \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status:  Single  Married  Widowed  Divorced

Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_

\_\_\_FULL TIME\_\_\_PART TIME \_\_\_NOT EMPLOYED \_\_\_SELF EMPLOYED \_\_\_RETIRED \_\_\_ACTIVE MILITARY DUTY \_\_\_STUDENT

Pharmacy: \_\_\_\_\_ Pharmacy Phone Number: ( ) \_\_\_\_\_

**HOW DID YOU HEAR ABOUT THE PRACTICE?** (check one)

Internet/Google  Friend/Family  Insurance  Facebook   
Doctor Referral  Other

Referred by: \_\_\_\_\_ Other: \_\_\_\_\_

**RELEASE OF PERSONAL INFORMATION TO THE PATIENT’S DESIGNEES**

*I authorized medical staff members of this practice to discuss my medical history, diagnosis, treatment and prognosis with other medical providers and organizations that participate in care and with those listed below.*

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____

**ASSIGNMENT OF INSURANCE BENEFITS**

*The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits and services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim.*

*I, \_\_\_\_\_, hereby authorize \_\_\_\_\_ to pay and hereby assign directly to Superior Podiatry all benefits. I further acknowledge that any insurance benefits, when received by and paid to Superior Podiatry, will be credited to my account in accordance with the above said assignment.*

*I, \_\_\_\_\_, as the patient, recognize that I am responsible for services and payment due at time of service rendered.*

*Insurance may be billable as a courtesy if appropriate information is provided by myself, the patient.*

**Agreed & Authorized:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**SOCIAL HISTORY**

Do or Did you smoke cigarettes?  Yes  No If Yes, packs per day? \_\_\_\_\_ Stop date: \_\_\_\_\_

Drink alcohol regularly?  Yes  No Do you exercise regularly?  Yes  No

Allergies to any medication?  Yes  No If Yes, which medications? \_\_\_\_\_

Place of Birth? \_\_\_\_\_ Unusual Occupational Exposures? \_\_\_\_\_

Please list ALL medications you are currently taking: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**MEDICAL HISTORY:**

Previous Surgery/Hospitalizations \_\_\_\_\_

Blood Transfusions (dates): \_\_\_\_\_

General Anesthesia: \_\_\_\_\_

Injuries and Fractures (types & dates): \_\_\_\_\_

**FAMILY HISTORY** (check if anyone in your family has had or had the following)

	MOTHER	FATHER	SILBINGS	CHILDREN	OTHER RELATIVE
CANCER					
DIABETES					
HEART DISEASE					
ARTHRITIS					
OSTEOPOROSIS					
AGE (IF LIVING)					

**SYSTEMIC REVIEW (DO YOU NOW HAVE OR EVER HAD THE FOLLOWING)**

	YES	NO		YES	NO
Chronic Headaches/Migraines			Diabetes		
Dizziness			High Blood Pressure		
Fainting Spells/Blackouts			High Cholesterol		
Eye Disease/Glaucoma/Cataracts			Joint Pains/Swelling		
Double Vision			Swelling of ___ Feet ___ Ankles		
Recent Vision Impairment			Numbness/Tingling of hand/Feet		
Impaired Hearing			Color Changes in the Hands		
Ringling in the Ears			Chest Pressure/Chest Pain		
Dryness of ___ Eyes ___ Mouth			Chronic Back Pain		
Recent Hair Loss			Chronic Neck Pain		
Asthma			Parkinsonism		
Recurrent Fever			Osteoporosis		
Thyroid Disorder			Sciatica		
Pneumonia			Anemia or Blood Disorder		
Pleurisy			Skin Rash		
Frequent Cough			Psoriasis		
Tuberculosis Exposure			Recent Weight ___ Gain ___ Loss		
Difficulty Breathing			Loss of Appetite		
Coughing Up Blood			Constant Thirst or Hunger		
Rheumatic Fever			Stomach/Duodenal Ulcer		
Difficulty Urinating			Abdominal Pain/Heart Burn		
Painful/frequent Urination			Frequent Nausea/Vomiting		
Blood in Urine			Heart Murmur		
Nighttime Urination ___ Times			Cancer		
Prostate Disorder			Palpitations		
Recurring Bladder Infections			Convulsions OR Epilepsy		
Kidney Disease/Stones			Hepatitis/Jaundice		
Pancreatitis			HIV Virus Positive		
Diverticulitis			Chronic Anxiety		
Phlebitis			Depression		
Insomnia					

Date of: Most Recent Medical Exam \_\_\_\_\_

EKG \_\_\_\_\_ Blood Tests \_\_\_\_\_ Chest X-Ray \_\_\_\_\_

Reason for office visit today: \_\_\_\_\_

\_\_\_\_\_