

**PATIENT INFORMATION FORM**

Date: \_\_\_\_\_

**PLEASE PRINT**

Male  Female

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Parent or Guardian (if a minor) \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Sec. #: \_\_\_\_\_ Email: \_\_\_\_\_ Employer: \_\_\_\_\_

Primary Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

Not Insured

Primary Insurance: \_\_\_\_\_ Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's Relationship to Insured:  Self  Spouse  Child  Other: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's Relationship to Insured:  Self  Spouse  Child  Other: \_\_\_\_\_

**MEDICAL HISTORY**

Reason for seeing doctor today: \_\_\_\_\_

Previous foot, ankle or leg problems/injury/surgery: \_\_\_\_\_

List any other operations and dates: \_\_\_\_\_

Other pertinent medical and family history or information: \_\_\_\_\_

Height: \_\_\_\_\_ ft \_\_\_\_\_ inches      Weight: \_\_\_\_\_ lbs      Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_

**Have you ever had or been treated for the following?**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Gout                  | <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> AIDS or related complex |
| <input type="checkbox"/> Stents in legs      | <input type="checkbox"/> Poor Circulation      | <input type="checkbox"/> Asthma                             | <input type="checkbox"/> Kidney problems         |
| <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Stomach ulcers/reflux | <input type="checkbox"/> Varicose veins                     | <input type="checkbox"/> Psoriasis               |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blood Clots           | <input type="checkbox"/> Heart Problems                     | <input type="checkbox"/> Arthritis               |
| <input type="checkbox"/> Knee/ankle injury   | <input type="checkbox"/> Foot injury           | <input type="checkbox"/> Back injury                        | <input type="checkbox"/> Herniated Disc          |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Bleeding Tendency     | <input type="checkbox"/> Peripheral neuropathy in legs/feet |  |

Do you wear orthotics? \_\_\_\_\_ Anything else Dr. Young should be aware of? \_\_\_\_\_

**CURRENT MEDICATIONS:** \_\_\_\_\_

**ALLERGIES:**  None

Penicillin  Codeine  Cortisone  Anesthetics  Vicodin  Demerol  Aspirin  Iodine Other: \_\_\_\_\_

Do you smoke?  Never  No  Yes \_\_\_\_\_ packs/day # years smoked \_\_\_\_\_

Occupation/job? \_\_\_\_\_ Hours/day on your feet at work? \_\_\_\_\_

What are your other frequent activities requiring your feet?  Sports  Exercise  Walking  Travel other \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Date Last Seen: \_\_\_\_\_

Address: \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Phone: \_\_\_\_\_

**REFERRED BY / HOW HEARD?**

- Doctor \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_
- Patient/Friend (name) \_\_\_\_\_
- PPO Insurance Directory    Physician’s Referral Service (St. Joseph’s)    Yellow Pages/Dex    Walk by/Sign
- Angie’s List    Internet Search (please specify):    Google    Yahoo    Facebook    Bing    Other: \_\_\_\_\_
- Advertisement (please specify) \_\_\_\_\_    Promotional Offer (please specify) \_\_\_\_\_
- Met Dr. Young at (specify) \_\_\_\_\_    Other \_\_\_\_\_

**PERMISSION TO TREAT:** I hereby give permission to Dr. Young to examine, to photograph, to administer treatment and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot problem.

Signature (patient or guardian): \_\_\_\_\_ Date: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have read (or had the opportunity to read if I so choose) and understood the notice. I understand that a paper copy will be provided to me if I request one.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:** I authorize **Debra E. Young, DPM, PC** to release any information regarding the medical history and treatment including disability related information to any third party payer (including Medicare), or their contracted agents, to validate or determine benefits payable for services rendered to myself or any dependents.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_