

# Southwest Podiatry Center

**PLEASE PRINT THE FOLLOWING INFORMATION. IT IS IMPORTANT FOR MY RECORDS AND YOUR HEALTH**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_ SEX: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ SOC SEC# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

FAMILY DOCTORS NAME: \_\_\_\_\_ DOCTORS ADDRESS \_\_\_\_\_

YOUR ADDRESS: \_\_\_\_\_ EMPLOYER NAME: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ EMPLOYER ADDRESS \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ EMPLOYER CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ EXT: \_\_\_\_\_ CELL PHONE \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

DRIVER'S LICENSE #: \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE: \_\_\_\_\_

LAST VISIT WITH FAMILY DOCTOR: \_\_\_\_\_

FORMER PODIATRIST: \_\_\_\_\_ LAST VISIT \_\_\_\_\_

ARE YOU IN GENERAL GOOD HEALTH'	YES _____	NO _____
IS THERE ANY FAMILY HISTORY OF DIABETES	YES _____	NO _____
DO YOU GET CRAMPS OR NUMBNESS IN YOUR FEET OR LEG	YES _____	NO _____
DO YOU EVER HAVE SWELLING IN YOUR FEET OR LEGS	YES _____	NO _____

ARE YOU BEING TREATED FOR

DIABETES	YES _____	NO _____	HIGH BLOOD PRESSURE	YES _____	NO _____
HEART TROUBLE	YES _____	NO _____	ASTHMA	YES _____	NO _____
TUBERCULOSIS	YES _____	NO _____	KIDNEY TROUBLE	YES _____	NO _____
LIVER TROUBLE.	YES _____	NO _____	RHEUMATIC FEVER	YES _____	NO _____
VARICOSE VEINS	YES _____	NO _____	ARTHRITIS	YES _____	NO _____
ANEMIA	YES _____	NO _____	BLOOD DISEASE	YES _____	NO _____
EPILEPSY	YES _____	NO _____	PROLONGED BLEEDING	YES _____	NO _____

ARE YOU ALLERGIC TO ANYTHING? \_\_\_\_\_

WHAT ARE THE NAMES OF ANY MEDICATIONS YOU ARE TAKING? \_\_\_\_\_

WHAT IS YOUR MAIN FOOT COMPLAINT? \_\_\_\_\_

BOTH FEET \_\_\_\_\_ RIGHT FOOT ONLY \_\_\_\_\_ LEFT FOOT ONLY \_\_\_\_\_

HOW LONG HAS IT BOTHERED YOU? \_\_\_\_\_ DO YOU HAVE ANY OTHER PROBLEMS

REGARDING YOUR FEET? \_\_\_\_\_

ARE YOU TO YOUR KNOWLEDGE AT THIS TIME PREGNANT? YES \_\_\_\_\_ NO \_\_\_\_\_

DO YOU HAVE ANY DISEASE OR CONDITION THAT YOU THINK I SHOULD KNOW ABOUT? \_\_\_\_\_

**D. M. SMITH, D.P.M., F.A.C.F.S., D.A.B.P.S.  
PODIATRIST**

**TREATMENT AGREEMENT**

I hereby give my permission to D.M. SMITH. D.P.M. to diagnose, to administer and to perform such procedures as it may be deemed necessary in the diagnosis and/or treatment of my feet and related conditions. I acknowledge that photos of myself or my feet may be taken and that personal photos will be solely utilized for patient identification, and that photos of my feet with no identification may be used for medical demonstrations and for lectures.

With regard to podiatric care and services provided or to be provided, it is agreed that D.M. SMITH. D.P.M.. his assistants(s) and or associates will provide podiatric care and services to me the patient to the best of their skill and knowledge, which podiatric care in the light of circumstances is possible and practical. The patient will cooperate fully with them by obtaining such medications as are prescribed, by following their instructions, by adhering to the treatment regimen or course of action as may be set forth and by paying all fees and charges in full as billed or provided by prior special arrangements. It is agreed that because of differences in human constitution and response it is in no way possible to warrant the outcome of such podiatric care and service.

**Acknowledgment of receipt of notice of privacy practices**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

PARTY RESPONSIBLE FOR PAYMENT OF THE ACCOUNT \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

ADDRESS OF RESPONSIBLE PARTY \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMPLOYER OF RESPONSIBLE PARTY \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

FEES FOR OFFICE VISITS, DIAGNOSTIC X-RAYS, AND OPERATING SUPPLIES ARE TO BE PAID WHEN SERVICES ARE RENDERED. IF NOT, OTHER ARRANGEMENTS MUST BE MADE WITH OUR OFFICE AT THE TIME OF THE VISIT.

MEDICAL INSURANCE INFORMATION:

INSURANCE COMPANY \_\_\_\_\_

GROUP NO# \_\_\_\_\_

SUBSCRIBER NO# \_\_\_\_\_

MEDICARE NO# \_\_\_\_\_