Big Apple Foot & Ankle Care
COSMETIC FOOT CARE & RECONSTRUCTIVE SURGERY

PATIENT INFORMATION

Date:_____

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Age: _____ Social Security Number#: _____

Male: _____Female: _____ Marital Status: Single / Married / Widowed / Separated

Home Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Home Phone #:_____ Cell Phone #: _____ Email Address: _____

Height: _____ Weight: _____ Shoe Size: _____

Spouse/Partner Name: _____

Are you Employed: [ ] None [ ] Full Time [ ] Part Time [ ] Retired [ ] Student

Patient Occupation: _____ Employer Name: _____

Employer Address: _____ Phone#: _____

If patient is a minor: Parent/Guardian Name: _____

Phone #: _____ Cell Phone #: _____

Emergency Contact Name: _____Phone: _____

General Physician's Name: _____Date of last visit:_____

INSURANCE INFORMATION

Insurance Company _____Policy ID# _____ Group#_____

Insured Name _____ Relationship to Patient _____

Insured Birth Date _____ Is this patient covered by additional insurance? YES NO

How did you hear about our office? Is this person: □ Other Specialist □ Family Member □ Friend

Other source: □ Insurance Plan Website □ Internet search □Our Website □ Walked by office □Other_____

Height: _____ Weight: _____ Shoe Size: _____

MEDICAL HISTORY

HAVE YOU OR A FAMILY MEMBER EVER BEEN TREATED FOR ANY OF THE FOLLOWING CONDITIONS? Please check all that apply to you:

→ put an **M** if on your mother's side → put an **F** if on your father's side

□Acid Reflux □Anemia □Arthritis □Asthma □ Bleeding Disorders

□Cancer □ Depression □ Diabetes □ Epilepsy □ Fatigue

□ Fibromyalgia □ Headaches □ Heart Condition □ Hepatitis □ High Cholesterol

□ HIV/Aids □ Hypertension □ Hyperthyroidism □ Hypothyroidism □IBS

□Kidney Disease □ Liver Disease □ Nervous Disorder □ Muscle or Joint Pain □ Phlebitis

□Peripheral Arterial Disease □ Parkinson's Disease □ Poor Circulation □ Respiratory Disease

□Rheumatic Fever □Shortness of Breath □ Seizure Disorders □Stroke

□ Stomach Ulcers □Varicose Veins □Celiac Disease

Do you currently use: Cigarettes or Tobacco? Yes□ No □ Quit□

If yes, for how long?_____ How many packs/day? _____ If quit, when? _____

Years: _____ Months: _____

Alcohol use? Yes□ No □ if yes, how much? Daily: _____ Weekly: _____

MEDICATIONS

Are you currently on blood thinners? Yes □ No□

Please provide a printed list of your medications or list them below:

NAME OF MEDICATION	STRENGHT/MG.	HOW OFTEN?
_____	_____	_____
_____	_____	_____
_____	_____	_____

SURGERIES

Please list all surgeries and the date/year.

_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Have you ever had any adverse side effects or allergies to:

Adhesive Tape: YES NO

Anticoagulants: YES NO

Anti-Inflammatory Meds: YES NO

Aspirin: YES NO

Codeine: YES NO

Cortisone: YES NO

Iodine: YES NO

Latex: YES NO

Metal/Jewerly: YES NO

Novacaine: YES NO

Peanuts: YES NO

Penicillin: YES NO

Seafood: YES NO

Other antibiotics: YES NO

Other pain medication: YES NO

Other: YES NO

If other please explain: _____

PODIATRIC HISTORY

Have you ever been to a Podiatrist before? □Yes □No

What is the main reason for your visit today?

_____

When did the problem begin? _____

Did you receive prior treatment for this condition? □Yes □No

If so what type? _____

Circle the degree of pain you are currently experiencing:

Minimal 1 2 3 4 5 6 7 8 9 10 Severe

Have you ever had any of the following foot conditions?

Please check all that apply:

□Ankle Instability □Arthritis □Back Pain □Blisters □Bone Spurs

□Bunions □Burning Feet □Corns/Calluses □Diabetic Evaluation □Flat Feet

□Fracture □Fungal Infections (skin/nail) □Gout □Hammertoes

□Heel Pain □Hip Pain □Infections □Ingrown Toenails □Intoe-Out toe walking

□Joint Pain □Knee Pain □Limb Length Discrepancy □Numbness or tingling in foot or toes

□Plantar Fasciitis □Pronation □Shin Splints □Sprains

□Sweating/Odor □Tendonitis □Tired Feet □Ulcers □Warts

SPORTS & ACTIVITIES:

_____
_____
_____

SIGNATURE ON FILE AND PERSMISSION TO TREAT:

□ I understand that the information provided on this form is true and correct to the best of my knowledge.

□ I request that payments of authorized benefits be made on my behalf for any services furnished by John Mwando DPM.

□ I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent.

□ I recognize my financial obligation of any coinsurance, co-pays, or deductibles and on-conversed services that maybe required.

□ I hearby give person to John Mwando DPM and any qualified staff to evaluate, diagnose and treat my foot condition as may be deemed necessary.

Patient or Authorized Signature: _____

If not Patient state relationship: _____ Date: _____

Patient's Pregnancy Evaluation Form

Dear Patient,

In order for us to fully evaluate you we are required to take x-rays of some part(s) of your body. It has been predicted that an unborn child in its first trimester would be more sensitive to radiation than an adult. In order to insure that accidentally, knowingly or otherwise, no Fetus (unborn child) be exposed to radiation from x-ray machines, we ask you to provide us with the following information. We thank you for the information and this information is strictly confidential and is solely used for the purpose it is intended.

DATE: _____

NAME: _____

DATE OF THE ONSET OF LAST MENTRUAL PERIOD: _____

IS THERE ANY CHANCE THAT YOU MAY BE PREGNANT? YES / NO

To the best of my knowledge, I am not pregnant and by providing this application for Physician/Technologist has informed me of the effects of Radiation to the Unborn baby and me by signing below have consented to taking the x-rays of my body parts for further studies.

SIGNATURE: _____

Assignment of Benefits

I hereby assign any rights I may have under my insurance agreement to the extent necessary for the facility to recover any medical expense benefits due to me.

I certify that my policy is active on the date of service and my assignment of benefits is accepted by my doctor at the Big Apple Foot Care.

If any payments are made directly to the policy holder (you), all payments and accompanying Explanations of Benefits (EOB) are required to be transmitted immediately to me.

If you do not promptly comply with our office protocol, I will have no other alternative but to bill you directly and in full for services provided to you.

Patient Name (Please Print)_____

Signature _____ Date:_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

I, _____have received a copy of the Patient Privacy Practice.
(Patient Name/Please Print)

_____ _____
(Signature of Patient or Legal Guardian) (Date)