choicePodiatry ASSOCIATES

ESTABLISHED PATIENT UPDATE

Dr. John Rootring **Dr. Jay Feist**

DEMOGRAPHICS

Legal Name ______________________________ Date of Birth ______________
First Name Middle Initial Last Name

Gender: ☐Female ☐Male Marital Status: ☐Married ☐Divorced ☐Widowed ☐Single

SS#________-________-__________ E-mail Address: ______________________________

If patient is a minor, Parent's Full Name:______________________________

Home Phone #______________________Cell Phone #______________________

Mailing Address____
Street City State Zip

Employer______________________Occupation______________________☐Full-time ☐Part-time ☐Retired ☐Student

Emergency Contact: ______________________ This is my ☐Spouse ☐Relative ☐Friend ☐Other__________

Home Phone # ______________________ Cell Phone Number # ______________________

Family Doctor / PCP:______________________Phone:______________

Were you referred by your Primary Care Physician? ☐Yes ☐No

How did you hear about us?
☐ Friend/Relative/Patient______________________☐Other______________________
☐Internet ______________________

INSURANCE & PAYMENT INFORMATION

Please hand your card to our receptionist. A copy will go in your medical record.

Primary Insurance Company:______________________ Policyholder's Name: ______________________
ID #______________________Group #______________ Patient's relationship to policyholder: ☐Self ☐Spouse ☐Child
Policyholder's SS #________-________-__________ Policyholder's Date of Birth ______________________

Secondary Insurance Company:______________________ Policyholder's Name: ______________________
ID #______________________Group #______________ Patient's relationship to policyholder: ☐Self ☐Spouse ☐Child
Policyholder's SS #________-________-__________ Policyholder's Date of Birth ______________________

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Demographics:
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino
Language: ☐ English ☐ Spanish ☐ Other ______________________
Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Other

Permission to Treat / Release of Information/Privacy Practices:

1. I HEREBY give my permission to Choice Podiatry to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my extremity condition. I HEREBY assign to Choice Podiatry all benefits provided by my insurance company policy/policies for medical & surgical care. I HEREBY acknowledge Receipt of Notice of Privacy Practices. I have been provided a copy of the Notice of Privacy Practices and I have read (or had the opportunity to read if I so choose) and understood the Notice.

2. I AUTHORIZE Choice Podiatry to email, text or call me for appointment reminders/changes, follow-up of treatment or any outstanding issues with my account via ☐ Phone Numbers Provided Above ☐ Email listed above ☐ Both

____ ______________
PATIENT SIGNATURE (PARENT/GUARDIAN IF PATIENT IS A MINOR) DATE

choicePodiatry
ASSOCIATES

Established Patient Medical History Update

Name: ____ **Date:** ____________________________________

Date of Birth: __________________________________ **Shoe Size:** _________________________________

Height: _______________________________________ **Weight:** ___________________________________

Home Phone: ___________________________________ **Cell Phone:** ________________________________

Alternate Contact Name / Cell Phone: ____

What are you being seen for today? ____

Are you **ALLERGIC** or sensitive to any medications? ______ YES ______ NO
If yes, please list the medications and what happens when you take them.

____
____
____

Please list **ALL MEDICATIONS** you are taking along with the strength and how often you take them. (If you have a list with you, **we can make a copy**) If you need more space, please use the back of page.

____
____
____

Are you currently taking Coumadin, Aspirin, Plavix or any other types of blood thinners? ___YES ___NO

Do you currently have or had any of the following? (Please **CIRCLE** all that apply)

Anemia	Blood Clots / DVT	High Blood Pressure	Poor Circulation
Alzheimer's	Cancer	High Cholesterol	Psoriasis / Eczema
Arthritis	Diabetes	HIV / AIDS	Scarlet Fever
Artificial Heart Valve	Dementia	Kidney Disease	Stomach Ulcer
Artificial Joints	Epilepsy	Liver Disease	Stroke
Asthma	Gout	Numbness in Feet	Thyroid Problems
Back Problems	Heart Disease	Osteoporosis	Tuberculosis
Bleeding Disorder	Hepatitis	Parkinson's Disease	

If diabetic, what was your last A1C score? _____________________

Do you currently smoke? Yes ________ No _________

Primary Care Physician: ___________________________ **Phone Number:** ________________________

Pharmacy Name: _______________________________ **Phone Number:** ________________________

Pharmacy Zip Code: ___________________________