Podiatry Associates of Victoria, P.A.

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Patient Information

Date _____

Name _____ **Soc. Sec#** _____
Last Name **First Name** **Initial**

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Sex : ❑ Male ❑ Female **Birth Date** _____ **Age** _____ **E-mail** _____

Marital Status : ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced **Spouse / Guardian Name** _____

Employer _____ **Occupation** _____

Business Address _____ **Business Phone** _____

Primary Physician _____ **Last Visit** _____ **Who can we thank for referring you?** _____

Notify in case of emergency _____ **Home#** _____ **Cell#** _____ **Work#** _____

Race _____ **Ethnicity: Hispanic Yes / No** **Preferred Language** _____

Person Responsible for account _____ **Relationship to Patient** _____

Birth Date _____ **SS#** _____ **Employer** _____

Address _____ **Home #** _____ **Cell #** _____

Primary Insurance

Name of Insured _____ **Birth Date** _____ **SS#** _____

Address (if different from patient) _____ **City** _____ **State** _____ **Zip** _____

Insurance Company _____ **ID#** _____ **Group #** _____

Other dependants named under this plan _____

Additional Insurance

Is the patient covered by additional insurance? ❑ **Yes** ❑ **No**

Name of Insured _____ **Birth Date** _____ **SS#** _____

Address (if different from patient) _____ **City** _____ **State** _____ **Zip** _____

Insurance Company _____ **ID#** _____ **Group #** _____

Other dependants named under this plan _____

BACK ➡

Health History

Please check the boxes below if you have ever had any of the following conditions

Medical History

- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Atrial Fibrillation
- ☐ Asthma
- ☐ Back Pain
- ☐ Cancer (Type_____)
- ☐ Chemical Dependency
- ☐ Chest Pain
- ☐ Circulatory Problems
- ☐ Bleeding/Bruising Tendency
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Ear/Nose/Throat Problems
- ☐ Eye Problems
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Headaches
- ☐ Head Injury
- ☐ Heart Problems / Disease
- ☐ Hepatitis / Liver Disease
- ☐ High Blood Pressure
- ☐ HIV / Aids
- ☐ Kidney Problems
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Slow to heal
- ☐ Stomach Problems / Ulcers
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tremors
- ☐ Tuberculosis

Podiatric History

- ☐ Ankle Break / Sprain
- ☐ Arch Pain
- ☐ Bunions
- ☐ Callouses
- ☐ Corns
- ☐ Cold extremities
- ☐ Difficulty walking
- ☐ Flat Foot
- ☐ Foot Break / Sprain
- ☐ Gout
- ☐ Hammertoe
- ☐ Heel Pain
- ☐ High Arches
- ☐ Ingrown Toenails
- ☐ Intoeing
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Leg Pain
- ☐ Neuroma
- ☐ Numbness
- ☐ Muscle pain
- ☐ Paralysis
- ☐ Rash
- ☐ Tingling in feet
- ☐ Tired Feet
- ☐ Varicose Veins
- ☐ Warts
- ☐ Weakness

Social History

- ☐ Tobacco use (Amount_____)
- ☐ Alcohol use (Amount_____)
- ☐ Caffeine use

Allergies

- ☐ Penicillin
- ☐ Codeine
- ☐ Morphine
- ☐ Lidocaine
- ☐ Sulfa
- ☐ Tape
- ☐ Aspirin
- ☐ Iodine

Surgical History

- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Breast Biopsy
- ☐ Cardiac Catheterization
- ☐ Carotid Artery Surgery
- ☐ Carpal Tunnel Release
- ☐ Cataracts
- ☐ Coronary Bypass Surgery
- ☐ Gallbladder Excision
- ☐ Gastric Bypass
- ☐ Hammertoe Repair
- ☐ Heart Valve Replacement
- ☐ Hemorrhoidectomy
- ☐ Hernia Repair
- ☐ Hip Surgery
- ☐ Hysterectomy
- ☐ Kidney Surgery
- ☐ Knee Surgery
- ☐ Mastectomy
- ☐ Mitral Valve
- ☐ Pacemaker
- ☐ Plastic Surgery
- ☐ Prostate Surgery
- ☐ Shoulder Surgery
- ☐ Sinus Surgery
- ☐ Tonsillectomy
- ☐ Thyroid Surgery
- ☐ Vein Stripping
- ☐ Wisdom Teeth
- ☐ Other_____

Podiatric Surgery

- ☐ Ankle Surgery
- ☐ Bunionectomy
- ☐ Heel Spur Excision
- ☐ Neuroma Excision
- ☐ Plantar Fascial Release
- ☐ Spur Excision
- ☐ Toenail Surgery
- ☐ Other_____

Additional Allergies:_____

Medications:_____

_____

Physicians you have seen in the last year: _____

Weight:_____ Height:_____ Shoe Size:_____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all insurance submissions

I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____Date_____

Payment is due in full at time of treatment unless prior arrangements have been approved.