LoCicero Medical Group
Multi-Specialty Private Practice

Podiatry
New Patient Forms

Please do not mail or fax this form.
Bring it with you to your appointment.

Referred by: _____

Reason for today's visit: _____

Patient Name:

_____

Address:

_____
Street **City** **State** **ZIP Code**

Email address:

_____

Home phone: (_____) _____ **Emergency phone**: (_____)_____

Date of Birth: _____ **Sex**: M / F **Marital status**: _____

Social Security #: _____ **Student**: Y / N **If yes**: Full- or Part-time

Are you Hispanic or Latino: Y / N

Circle one or more of the following groups in which you consider yourself to be a member:

American Indian or Alaska Native Black or African American Native Hawaiian or Pacific Islander

Asian White or Caucasian Unknown Prefer not to respond

Languages Spoken: English Spanish Other: _____

Occupation: _____

Employer: _____

Address: _____
Street **City** **State** **ZIP Code**

Phone: (_____) _____ **Extension**: _____

Emergency Contact: _____

Primary phone: (_____) _____ **Alternate phone**: (_____)_____

Address: _____
Street **City** **State** **ZIP Code**

Primary Insurance Company: _____

Claims Address: _____
Street City State ZIP Code

Name of Insured: _____ **ID # of Insured**: _____

Group # of Insured: _____ **Relationship to Insured**: _____

Date of Birth of Insured: _____ **Social Security # of Insured**: _____

Secondary Insurance Company: _____

Claims Address: _____
Street City State ZIP Code

Name of Insured: _____ **ID # of Insured**: _____

Group # of Insured: _____ **Relationship to Insured**: _____

Date of Birth of Insured: _____ **Social Security # of Insured**: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date: _____ **Signature**: _____

I hereby authorize LoCicero Medical Group to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made to LoCicero Medical Group or to the party who accepts assignment.

I certify the information I have provided with regard to my insurance is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may only be revoked by either me or my insurance company in writing.

Date: _____ **Signature**: _____

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I will be responsible for payment of any allowable charge that my insurance coverage does not pay. I also understand that I will be responsible for services rendered that are not considered a covered benefit by my insurance company.

Date: _____ **Signature**: _____

PATIENT _____ DATE _____

MEDICAL HISTORY **INITIAL VISIT**

Describe your foot problems and/or symptoms

1.) _____

How long have you has this problem? _____ Days Weeks Months

2.) _____

How long have you had this problem? _____ Days Weeks Months

3.) _____

How long have you had this problem? _____ Days Weeks Months

Describe any past problems with your feet or ankles:

_____

_____

List any past surgical procedures on your feet or ankles and approximate dates:

1.) _____ Date: _____

2.) _____ Date: _____

3.) _____ Date: _____

Shoe Size: _____ Special Shoes? _____ Current Weight? _____ Height _____

Do you use? (Y or N) Walker _____ Crutches _____ Cane _____ Wheel Chair _____

Are you allergic or sensitive to:

Antibiotics: (Penicillin, Sulfa drugs, etc.) If yes please list

_____

Anti-inflammatory medicines: (Naprosyn, Vioxx, Voltarin, etc.)

_____

Over the counter pain relievers: (Motrin, Aleve, Tylenol, Advil, etc.)

_____

Other medicine allergies: _____

Any problems with local anesthetics (Novocaine, Lidocaine, etc.)? Y N

Do you have or have you had any of the following conditions? Y or N

_____ High Blood Pressure	_____ Arthritis	_____ Leg Cramps
_____ Heart Disease	_____ Gout	_____ Varicose Veins
_____ Poor Circulation	_____ Visual Problems	_____ Blood Clots
_____ Stomach Ulcers	_____ Anemia	_____ Stroke
_____ Kidney Disease	_____ Skin Problems	_____ Cancer
_____ Toenail Problems	_____ Asthma	_____ Seizures
_____ Joint Replacement	_____ Night Sweats	_____ Cold Feet
_____ Ankle/Foot Swelling	_____ Foot Tingling	_____ Lung Disease

Do you have diabetes? Y N If yes, do you take insulin? Y N

When diagnosed _____ Treating physician _____

Date of last treatment: _____

List any serious illness (last 10 years)

_____

_____

_____

List any major surgeries (last 10 years)

_____

_____

_____

Are you presently under a physician's care Y N

If so, list the condition being treated and the physician

Condition: _____ Physician: _____

Condition: _____ Physician: _____

Condition: _____ Physician: _____

Condition: _____ Physician: _____

What medications do you take regularly?

_____

_____

What pharmacy do you prefer to use? _____

Social History: Marital Status S M W D

Employment Status FT PT Unemployed Retired

Do you smoke? Y N If so, number of packs per day _____

Have you previously smoked? Y N When did you quit? _____

Do you smoke cigars, pipes or use smokeless tobacco products? Y N

Do you exercise? Y N If so, describe activities and frequencies _____

_____

Family History:

Mother Living _____ Deceased _____ Cause of death _____
Father Living _____ Deceased _____ Cause of death _____
Brother(s) Number _____ How many living _____ Causes of death _____
Sister(s) Number _____ How many living _____ Causes of death _____

Any family history of the following diseases? If so, which family member?

Heart Disease	M	F	B	S	Arthritis	M	F	B	S
Cancer	M	F	B	S	Bleeding Disorder	M	F	B	S
Diabetes	M	F	B	S	Stroke	M	F	B	S
Neurologic Disorder	M	F	B	S	Circulation Problems	M	F	B	S
High Blood Pressure	M	F	B	S	Vascular Disorders	M	F	B	S

Reviewed by Dr: _____ Date: _____