# *PETER C SMITH, DPM*

***DIPLOMATE, AMERICAN BOARD of FOOT and ANKLE SURGERY***

## NEW PATIENT INFORMATION FORM

1. NAME: (MR., Mrs., Ms.) _____DOB: _____
2. ADDRESS: _____City: _____State: _____ Zip_____
3. PHONE: _____ Cell: _____ Emergency: _____
4. EMAIL: _____
5. MEDICAL DOCTOR: _____ LAST VISIT: _____
6. PHARMACY: _____
7. EMPLOYER: _____OCCUPATION: _____
8. MARRIED: Y N SPOUSE NAME: _____
9. HOW DID YOU HEAR ABOUT OFFICE/WHO REFER YOU: GOOGLE INTERNET FACEBOOK

   FRIEND/FAMILY_____ DOCTOR OFFICE

## INSURANCE INFO

**PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD AND PHOTO ID**

1. PRIMARY INS SUBSCRIBER: _____DOB: _____
2. RELATION TO SUBSCRIBER: _____
3. SECONADRAY INS: _____

**CONSENT TO TREAT**

**I give Peter C Smith, DPM permission to examine and treat my feet, ankles and lower extremities, medically, orthopedically or surgically as he deems fit after he has thoroughly discussed this with me including the Alternatives, Risks and Complications of said treatment. I also give him permission to perform minor surgical procedures as may be deemed necessary for the treatment of my condition again after discussing the Alternatives, Risks, and Complications.**

**ASSIGNMENT of BENEFITS**

**I authorize Dr. Peter C Smith to bill my insurance company and for the insurance company to pay him directly for my medical and surgical claims. I also authorize the release of any information to my insurance company necessary to process the claims.**

**MEDICARE PATIENTS**

**I authorize that the payment of Medicare / Medigap / Medicare Advantage benefits be made either to me or on my behalf to the name of provider of service and / or supplier for any services furnished to me by that provider of service and / or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and it's agents any information needed to determine these benefits or the benefits payable to the related service.**

PATIENT NAME: _____ DATE: _____

PATIENT SIGNATURE: _____

PARENT or LEGAL GUARDIAN or POA: _____

## CURRENT FOOT/ANKLE PROBLEM

**1. Describe present problem: _____**

**2. When did it start? _____**

**3. What make it worse? _____**

**4. Have you seen a Podiatrist before, if so when? _____**

**5. ARE YOU UNDER HOSPICE CARE? _____**
***OFFICE USE ONLY: ABN (Yes NO)***

## PAST MEDICAL HISTORY

**1 List all allergies: _____**

**2. Current medications you take: _____**
**_____**

**3. Are you currently seeing your physician on a regular basis? _____**

**4. Do you have or have you had any of the following:**

| | | |
|---|---|---|
| **_____Diabetes T1 or T2** | **_____HTN/BP** | **_____Heart Surgery** |
| **_____Mitral Valve** | **_____Heart disease** | **_____PVD/PAD** |
| **_____Varicose Veins** | **_____Phlebitis/DVT** | **_____Anemia** |
| **_____Epilepsy/Seizures** | **_____Reflux/Stomach Dx** | **_____Neuropathy** |
| **_____Autoimmune Dx** | **_____Scarlet Fever** | **_____Artificial Joint** |
| **_____Liver Disease** | **_____Hepatitis** | **_____Lung Disease** |
| **_____Tuberculosis** | **_____Asthma** | **_____Kidney Disorders** |
| **_____Cancer** | **_____Gout** | **_____Arthritis** |
| **_____Thyroid Condition** | **_____Scarring Tendency** | |

**6. Other Conditions: _____**

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**7. Past Surgeries:**
**_____**

**8. If female: Are you pregnant? _____**

**9. Family History: _____Diabetes _____Heart Disease _____Stroke**
**_____HTN _____Cancer _____Arthritis _____Other**

**10. Do you: _____Smoke _____ppd _____yrs? Drink coffee/tea:_____**

**_____Drink alcohol**

**11. Exercise/Fitness Routine (miles/days per week/ how long etc):_____**

**_____**

**12. Type of work: _____How long at present job? _____**

**13. Type of shoes worn most often: _____**

**ACKNOWLEDGMENT OF RECEIPT**
**OF**
**Dr. Peter C. Smith's**
**NOTICE OF PRIVACY and FINANCIAL PRACTICES**

## HIPAA

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

## Financial Policy

I have been furnished a copy of or have read the Financial Policy of Dr. Peter C. Smith and understand all the terms, conditions and requirements applicable to my payment obligations to Dr. Peter C. Smith, DPM.

_____ _____
Patient Name (please print) Date

_____
Signature

_____
Parent or Authorized Representative

I authorize you to release my medical information to the following people on my behalf:

| NAME | RELATIONSHIP |
|---|---|
| NAME | RELATIONSHIP |
| NAME | RELATIONSHIP |
| NAME | RELATIONSHIP |