GALBRAITH
PODIATRY GROUP

New Patient Documentation

Name: ____
(Last) (First) (Middle)

Address: ____
(Street) (Apt#) (City) (State) (Zip)

Home Phone: (___)_______________ Cell: (__)_________________Work: (___)____________

Age: ____ Birthdate: ________ E Email: ____

Social: ___ ___ ___ Sex: Male Female Height:____ Weight:____ Shoe: ____

Occupation: _____________________________ Employer: _______________________________

Emergency Contact: ____(__)_____________

Marital Status: S M Spouse: ______________(__)___________

Insured: YES NO Are You The Policy Holder: YES NO

Guarantor If different from above: *(Billing Responsibility For This Account)*

Name: ____
(Last) (First) (Middle)

Address: ____
(Street) (Apt#) (City) (State) (Zip)

Employer: _______________________________ Birthdate: ________ Phone: (___)___________

If you did not bring your insurance cards with you, all charges will be your responsibility and payable at the time of visit. Obtaining referral forms and treatment pre-certification is the patient responsibility. Be prepared to pay for you full amount for co-pay.

If you are on MEDICARE and DIABETIC, please make sure that you have the date of the most recent blood sugar or A1-C done in your physician's office.

All unpaid balances and/or denied insurance claims are your responsibility.

Primary Insurance: ___________________ Group Number: _________ Policy Number: _______
Secondary Insurance: _________________ Group Number: _________ Policy Number: _______

Physicians Name: _______________________ Phone: (___)________
Hospital Affiliation: ____
Referral Name: ____

What is your foot problem:
____
____

How long have you been experiencing this? ____

Have you been treated for this before: YES NO
If YES, who was the servicing Physician: ____

Is this a work related injury? YES NO

MEDICAL HISTORY

Measles	Bowel Problems	Fevers over 103	Prolonged Bleeding
Mumps	Cancer	Heart Disease	Psych Problems
Chickenpox	Cataract	High Blood Pressure	Seizure
Rheumatic Fever	Cellulitis	Low Blood Pressure	STDs
AIDS	COPD	Hepatitis	Skin Problems
HIV+	Depression	Kidney Disease	Stroke
Anemia	Diabetes	Liver Disease	Swelling of Feet
Arthritis	Digestive Issues	Migraines	Tuberculosis
Asthma	Dizziness	Numbness	Transplant
Balance Problems	ENT Problems	Pacemaker	Ulcers
Bladder Problems	Epilepsy	Pneumonia	Varicose Veins
Blood Transfusion	Fainting	Polio	Vision Problems

Prior Hospitalizations, Surgeries, or Illness:

Joint replacement? YES NO

Heart valve replacement? YES NO

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Are your pregnant? *(Women)* YES NO

What Medicines are you taking now?

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Are you under Physician Care? ____

SOCIAL INFORMATION

Do you live alone? YES NO

Do you have Children? YES NO

Do you exercise: YES NO

Are you on a special diet? YES NO

Do you smoke? YES NO
How many years? ____ Packs per day? ____

Do you drink alcohol? YES NO
How many drinks per week? _____

Do you have a history of substance abuse? YES NO

FAMILY INFORMATION

Please check any of the following that any one in your family has been diagnosed with, and provide the relationship.

Heart Disease	Cancer	Diabetes
Circulatory Disease	Hypertension	Arthritis
Neurological Problems	Skin Disease	Foot Disorders

Relationship to you:
____
____

Any other pertinent family history to provide:
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PERSONAL SYSTEMS REVIEW

Check all that apply

Constitutional Symptoms

In good health
Recent weight change
Fever
Fatigue
Weakness

Eyes

Glasses
Contacts
Blurred Vision
Double Vision

Ears/Nose/Throat

Hearing loss
Earaches
Ears ringing
Sinus Problems
Nose bleeds
Swollen Glands

Cardiovascular

Chest Pain
Swollen Feet
Swollen Ankles
Swollen Hands

Respiratory

Chronic cough
Shortness of breath

Gastrointestinal

Appetite loss
Nausea or vomiting
Diarrhea
Constipation
Blood in stool
Abdominal pain

Genitourinary

Frequent urination
Burning sensation
Blood in urine
Incontinence

Musculoskeletal

Joint pain
Stiffness
Swelling
Muscle pain
Back pain
Cold extremities
Difficulty walking

Integumentary

Rash(es)
Itching
Skin changes
Hair changes
Nail changes

Neurological

Headaches
Lightheaded
Dizziness
Convulsions/Seizure
Numbness
Tremors
Paralysis/Weakness

Psychiatric

Memory loss
Confusion
Nervousness
Depression
Anxiety
Insomnia

Endocrine

Excessive thirst
Excessive urination
Heat intolerance
Colt intolerance
Dry Skin

Hematologic

Slow healing
Easily bruising
Phlebitis
Transfusions

ALLERGIES

Check all that apply

Anesthetics
Silver
Antibiotics
Tape
Seasonal Allergies
Codeine
Pain Meds
Foods
Aspirin
Tetanus
IV Dye
Sulfa
Penicillin
Iodine
Latex

Other: ____

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PODIATRY GROUP

I request that payment of authorized benefits from my insurance carrier be made on my behalf to the provider listed on this form for any services furnished to me by the physician. I authorize any holder of medical information about me to release it to the listed insurer(s) and/or agents of these companies, any information needed to determine these benefits or the benefits for other related services. I hear by accept responsibility for any service(s) provided to me that is not covered by my insurance. I agree to pay all copays, coinsurance, and deductibles at the time services are rendered. I also accept responsibility for fees that exceed the payment made by my insurance; If Galbraith Podiatry Group does not participate with my insurance.

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Signature of patient or guardian

____

Print name of patient of guardian