GALBRAITH
PODIATRY GROUP

DATE: _____

LAST NAME | FIRST NAME | MIDDLE NAME

ADDRESS | CITY & STATE | ZIP CODE

HOME/CELL PHONE NUMBER | WORK PHONE NUMBER

_____@_____-_____-_____
EMAIL ADDRESS | SOCIAL SECURITY NUMBER

_____/_____/_____MALE OR FEMALE_____
DATE OF BIRTH | GENDER

EMPLOYER | OCCUPATION

SINGLE MARRIED WIDOWED DIVORCED
MARITAL STATUS | SPOUSES NAME AND PHONE NUMBER

ETHNICITY AND RACE | PREFERRED SPOKEN LANGUAGE

EMAIL PHONE CALL WRITTEN COMMUNICATION
PREFERRED COMMUNICATION

PRIMARY CARE PHYSICIAN | DIABETIC CARE PHYSICIAN & DATE OF LAST A1C/HGB

PRIMARY INSURANCE COMPANY | POLICY HOLDER NAME AND DATE OF BIRTH

SECONDARY INSURANCE COMPANY | POLICY HOLDER NAME AND DATE OF BIRTH

EMERGENCY CONTACT NAME & RELATIONSHIP | ADDRESS & PHONE NUMBER

RESPONSIBLE BILLING PARTY IF DIFFERENT THAN PATIENT – NAME, DATE OF BIRTH, ADDRESS, PHONE NUMBER AND SOCIAL SECURITY NUMBER

GALBRAITH
PODIATRY GROUP

DATE: _____

I REQUEST THAT PAYMENT(S) 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 SERVICE. I HEAR BY ACCEPT RESPONSBILITY FOR ANY SERVICE(S) PROVIDED TO ME THAT IS NOT COVERED BY MY INSURANCE. I AGREE TO PAY ALL COPAYS, COINSURANCE AND DEDUCTIBLE AMOUNTS AT THE TIME SERVICES ARE RENDERED. I ALSO ACCEPT RESPONSIBILITY FOR FEES THAT EXCEED THE PAYMENT MADE BY MY INSURACE; IF GALBRAITH PODIATRY GROUP DOES NOT PARTICIPATE WITH MY INSURANCE.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN **DATE**

HIPAA

ALTHOUGH OUR OFFICE HAS ALWAYS TREATED MEDICAL RECORDS AS CONFIDENTIAL, OUR GOVERNMENT NOW WANTS YOU TO RECEIVE A WRITTEN COPY OF HOW THIS OFFICE PROTECTS YOUR HEALTH RECORDS. YOU ARE WELCOME TO TAKE YOUR WRITTEN COPY OF OUR PRIVACY PRACTICES HOME WITH YOU AND READ IT AT YOUR CONVENIENCE. ADDITIONALLY, WE ARE REQUIRED BY LAW, TO OBTAIN YOUR SIGNATURE INDICATING THAT WE HAVE OFFERED THIS INFORMATION TO YOU. BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE BEEN OFFERED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICE.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN **DATE**

AUTHORIZED INDIVIDUALS/ORGANIZATIONS TO RECEIVE MEDICAL/BILLING INFORMATION:

MEDICAL & BILLING INFORMATION:

_____

_____

ONLY MEDICAL INFORMATION:

_____

_____

ONLY BILLING INFORMATION:

_____

_____

GALBRAITH
PODIATRY GROUP

DATE: _____

INJURY? IF YES, PLEASE PROVIDE TYPE OF INJURY & DATE OF OCCURRENCE CLAIM #

EXPLANATION OF INJURY

ADDRESS FOR CLAIM REP & PHONE NUMBER

REASON FOR OFFICE VISIT TODAY? DURATION OF FOOT PROBLEM

HAVE YOU BEEN TREATED FOR THIS CONDITION BEFORE? IF YES, PLEASE PROVIDE DATE AND PROVIDER

MEDICAL HISTORY

- ○ MEASLES/MUMPS
- ○ CHICKEN POX
- ○ RHEUMATIC FEVER
- ○ AIDS/HIV+, STDS
- ○ ANEMIA
- ○ ARTHRITIS
- ○ ASTHMA
- ○ BALANCE PROBLEMS
- ○ BLADDER PROBLEMS
- ○ BLOOD PRESSURE PROBLEMS
- ○ BLOOD TRANSFUSIONS
- ○ BOWEL PROBLEMS
- ○ CANCER
- ○ CELLULITIS
- ○ COPD
- ○ DEPRESSION
- ○ DERMATOLOGICAL PROBLEMS
- ○ DIABETES
- ○ DIGESTIVE ISSUES
- ○ DIZZINESS
- ○ ENT PROBLEMS
- ○ EPILEPSY
- ○ FAINTING
- ○ FEVERS OVER 103°
- ○ HEART DISEASE
- ○ HEPATITIS
- ○ KIDNEY DISEASE
- ○ LIVER DISEASE
- ○ MIGRAINES
- ○ NUMBNESS
- ○ PACEMAKER
- ○ PNEUMONIA
- ○ POLIO
- ○ PROLONGED BLEEDING
- ○ PSYCH PROBLEMS
- ○ SEIZURES
- ○ STROKE
- ○ SWELLING OF FEET
- ○ TUBERCULOSIS
- ○ TRANSPLANTS
- ○ ULVER
- ○ VARICOSE VEINS
- ○ VISION PROBLEMS
- ○ JOINT REPLACEMENT
- ○ HEART VALVE REPLACEMENT
- ○ ARE YOU CURRENTLY PREGNANT (WOMEN)?

_____Height _____Weight

GALBRAITH
PODIATRY GROUP

DATE: _____

PRIOR HOSPITALIZATIONS, SURGERIES OR ILLNESSES:
YOU MAY PROVIDE A COPY OF A LIST OF MEDICAL HISTORY

_____
_____
_____
_____
_____

FAMILY MEDICAL HISTORY

MEMBER	CURRENT DISEASE	HEALTH STATUS *GOOD, FAIR OR POOR*	DECEASED	CAUSE OF DEATH
FATHER				
MOTHER				
BROTHER(S)				
SISTER(S)				
CHILDREN				
OTHER RELATIVES				

SOCIAL INFORMATION

	YES	NO
DO YOU LIVE ALONE?		
DO YOU HAVE CHILDREN?		
DO YOU EXERCISE?		
ARE YOU ON A SPECIAL DIET?		
DO YOU SMOKE? HOW MANY YEARS? _____ PACKS PER DAY? _____		
DO YOU DRINK ALCOHOL? HOW MANY DRINKS PER WEEK? _____		
DO YOU HAVE A HISTORY OF SUBSTANCE ABUSE?		

GALBRAITH
PODIATRY GROUP

DATE: _____

MEDICATIONS

NAME	DOSAGE

ALLERGIES

_____

_____

_____

_____

PERSONAL REVIEW OF SYSTEMS

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/SEIZURES ___
NUMBESS ___
TREMORS ___
PARALYSIS/WEAKNESS ___

PSYCHIATRIC
MEMORY LOSS ___
CONFUSION ___
NERVOUSNESS ___
DEPRESSION ___
ANXIETY ___
INSOMNIA ___

ENDOCRINE
EXCESSIVE THIRST ___
EXCESSIVE URINATION ___
HEAT INTOLERANCE ___
COLD INTOLERANCE ___
DRY SKIN ___

HEMATOLGOIC
SLOW HEALING ___
EASY BRUISING ___
PHLEBITIS ___
TRANSFUSIONS ___