

DATE: _____

LAST NAME FIRST NAME MIDDLE NAME

ADDRESS CITY & STATE ZIP CODE

HOME/CELL PHONE NUMBER WORK PHONE NUMBER

EMAIL ADDRESS @ _____ - - -
SOCIAL SECURITY NUMBER

DATE OF BIRTH / / _____ MALE OR FEMALE
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

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 HERBY ACCEPT RESPONSIBILITY 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 INSURANCE; 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:

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

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

_____ Height _____ Weight

DATE: _____

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

**FAMILY MEDICAL HISTORY
HEALTH STATUS**

MEMBER	CURRENT DISEASE	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?		

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 ____
 NUMBNESS ____
 TREMORS ____
 PARALYSIS/WEAKNESS ____

PSYCHIATRIC

MEMORY LOSS ____
 CONFUSION ____
 NERVOUSNESS ____
 DEPRESSION ____
 ANXIETY ____
 INSOMNIA ____

ENDOCRINE

EXCESSIVE THIRST ____
 EXCESSIVE URINATION ____
 HEAT INTOLERANCE ____
 COLD INTOLERANCE ____
 DRY SKIN ____

HEMATOLOGIC

SLOW HEALING ____
 EASY BRUISING ____
 PHLEBITIS ____
 TRANSFUSIONS ____