

WELCOME TO OUR OFFICE
LOMBARD FOOT AND ANKLE CLINIC, P.C.
Dr. Esther Lyon

Today's Date:

PATIENT INFORMATION

Patient Name:		Social Security #:	
Address:			
street	city	state	zip
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Age:
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated		
Occupation:	Employer:		
Who may we thank for referring you?			

PATIENT PHONE NUMBERS

Home #:	Work #:	Ext:
Best time and place to reach you:		

PERSON TO NOTIFY IN AN EMERGENCY

Name:	Relationship to patient:
Home #:	Work #: Ext:

PODIATRIC HISTORY

Describe your foot and /or ankle problem:

How long has it been bothering you? (Describe in days, weeks, or years)

Have you been treated by a podiatrist before? Yes No

If yes, please list. Name: _____ Last visit date: _____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heel Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Athlete's Foot	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ingrown Toenails	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bunions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness in Feet or Legs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Corns and Calluses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Plantar's Warts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cramps in Feet or Legs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling in Ankles or Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Flat Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tired Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No

Describe any other past problems of your feet and/or ankles.

GENERAL HEALTH INFORMATION

Do you have Diabetes? Yes No If yes, indicate number of years: _____

Do you take insulin? Yes No Average blood sugar level? _____

Blood Pressure: _____ Height: _____ Weight: _____ Shoe Size: _____

Athletic activities in which you participate (please list and indicate frequency):

Family Doctor: _____ Last Visit Date: _____

Are you now, or have you been, under any doctor's care for any reason over the past two years? Yes No

If yes, please explain.

List surgeries you have had (indicate year):

List hospitalizations other than the surgeries listed (indicate year):

MEDICAL HISTORY

Please indicate if you have had any of the following:

Table with 3 columns of medical conditions and checkboxes for Yes/No. Conditions include AIDS/HIV, Anemia, Angina, Arthritis, Artificial Heart Valves or Joints, Asthma, Back Problems, Bleeding Disorders, Cancer, Chemical Dependency, Chest Pain, Chronic Diarrhea, Circulatory Problems, Diabetes, Ear Problems, Epilepsy, Difficulty with anesthesia, Eye Problems, Fainting, Foot or Leg Cramps, Gout, Headaches, Heart Disease, Heart Murmur, Hemophilia, Hepatitis or Jaundice, High Blood Pressure, Kidney Problems, Liver Disease, Low Blood Pressure, Nervous Problems, Phlebitis, Psychiatric Care, Radiation Treatment, Rash, Respiratory Disease, Rheumatic Fever, Shortness of Breath, Sinus Problems, Special Diet, Stroke, Swelling in Ankles, Feet, Swollen Neck Glands, Tired Feet, Tuberculosis, Ulcers, Varicose Veins, Venereal Disease, and Weight Loss, unexplained.

FAMILY MEDICAL HISTORY

Table with 3 columns of family medical conditions and checkboxes for Yes/No. Conditions include Coronary artery disease, Diabetes, Stroke, Vein or artery disease, Kidney disease, Liver disease, Bleeding disorders, Lung disease, Cancer, Neurological disease, High blood pressure, and Difficulty with anesthesia.

ALLERGIES TO MEDICATIONS

Please list any allergies to medications (i.e., Penicillin, Sulfa, Iodine, local anesthetics, foods, tape, etc.):

No, I do not have any allergies to any medications that I am aware of.

MEDICATIONS

Please list medications currently taking, include prescriptions, over-the-counter medications and vitamins:

Pharmacy Name: Pharmacy Phone #:

INSURANCE

Form for insurance information with fields for Primary Insurance Company, Secondary Insurance Company, Policy Holder's Name, Policy Holder's Social Security #, Policy Holder's Date of Birth, and Relationship of Policy Holder to Patient.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Esther Lyon for any services furnished me by that physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Signature Date

NOTICE OF PRIVACY PRACTICES

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) patients are to be made aware of their privacy rights. I have been given the opportunity to read the Privacy Law and I understand my privacy rights.

Patient's Signature Date

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature Date