

**WELCOME TO OUR OFFICE**  
**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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate number of years: _____		
	Do you take insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No	Average blood sugar level? _____	
Blood Pressure: _____	Height: _____	Weight: _____	Shoe Size: _____
Athletic activities in which you participate (please list and indicate frequency):			
Cigarette/tobacco use? <input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol Use <input type="checkbox"/> Yes <input type="checkbox"/> No How frequent?		
Do you use illegal substances for either medicinal or recreational purposes? If yes, explain			
Family Doctor Name & Phone Number		Last Visit Date:	
Are you now, or have you been, under any doctor's care for any reason over the past two years?			<input type="checkbox"/> Yes <input type="checkbox"/> 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 or anyone in your family have had any of the following:

	You		Family		You		Family		You		Family	
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot or Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valves or Joint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in Ankles, Feet	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Neck Glands	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tired Feet	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vein or Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sudden Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any of the above please explain.

**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**

Primary Insurance Company: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Policy Holder's Social Security #: \_\_\_\_\_

Policy Holder's Social Security #: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_

Relationship of Policy Holder to Patient: \_\_\_\_\_

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

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 receive a copy of the notice of Privacy Practices.

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 \_\_\_\_\_

**MINOR CONSENT**

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 son/daughter's \_\_\_\_\_ feet.

Parent's Signature \_\_\_\_\_

Date \_\_\_\_\_