Dr. Richard B. Haas D.P.M.
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# W E L C O M E

## PATIENT INFORMATION

Date _____

Patient _____

Address _____

City _____ State ____ Zip _____

Sex ☐ M ☐ F Age ____ Birthdate _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS # _____

Occupation _____

Employer _____

Employer Address _____

_____

Employer Phone # _____

Spouse's Name _____

Spouse's Birthdate _____ SS # _____

Spouse's Occupation _____

Spouse's Employer _____

Who may we thank for referring you? _____

## PHONE NUMBER

Home _____ Work _____

Best time and place reach you _____

**IN CASE OF EMERGENCY, CONTACT**

Name _____ Relationship _____

Home _____ Work _____

## INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____

Birthdate _____ SS # _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent ) have insurance coverage with _____

and assign directly to Dr. **HAAS**

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

I authorize the use of this signature on all insurance submissions.

x _____

Responsible Party Signature

_____ _____

Relationship Date

### MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. **HAAS** for any services furnished me by that physician. I authorize any holder of medical information about me to release 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 payment 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.

_____ _____

Beneficiary Signature Date

## PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

_____

Have you ever been to a Podiatrist before? ☐ Yes ☐ No

If yes, please list.

Name _____

Last visit _____

Is there any personal or family history of diabetes? ☐ Yes ☐ No

Your Occupation _____

Cigarette/Tobacco Use _____

Years Smoked _____

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

_____

_____

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

| | | |
|---|---|---|
| Ankle Pain | ___ Yes | ___ No |
| Athlete's Foot | ___ Yes | ___ No |
| Bunions | ___ Yes | ___ No |
| Corns and Callouse | ___ Yes | ___ No |
| Cramps or Numbness | | |
| In Feet or Legs | ___ Yes | ___ No |
| Flat Feet | ___ Yes | ___ No |
| Foot or Leg Cramps | ___ Yes | ___ No |
| Heel Pain | ___ Yes | ___ No |
| Ingrown Toenails | ___ Yes | ___ No |
| Plantar's Warts | ___ Yes | ___ No |
| Swelling in Ankles or Feet | ___ Yes | ___ No |
| Tired Feet | ___ Yes | ___ No |

# MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐ Yes | ☐ No | Epilepsy | ☐ Yes | ☐ No | Radiation Treatment | ☐ Yes | ☐ No |
| Allergies to Anesthetics | ☐ Yes | ☐ No | Eye Problems | ☐ Yes | ☐ No | Rash | ☐ Yes | ☐ No |
| Allergies to Medicine or Drug | ☐ Yes | ☐ No | Fainting | ☐ Yes | ☐ No | Respiratory Disease | ☐ Yes | ☐ No |
| Anemia | ☐ Yes | ☐ No | Foot or Leg Cramps | ☐ Yes | ☐ No | Rheumatic Fever | ☐ Yes | ☐ No |
| Angina | ☐ Yes | ☐ No | Gout | ☐ Yes | ☐ No | Shortness of Breath | ☐ Yes | ☐ No |
| Arthritis | ☐ Yes | ☐ No | Headaches | ☐ Yes | ☐ No | Sinus Problems | ☐ Yes | ☐ No |
| Artificial Heart Valves or Joints | ☐ Yes | ☐ No | Heart Disease | ☐ Yes | ☐ No | Special Diet | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No | Hemophilia | ☐ Yes | ☐ No | Stroke | ☐ Yes | ☐ No |
| Back problems | ☐ Yes | ☐ No | Hepatitis or Jaundice | ☐ Yes | ☐ No | Swelling in Ankles, Feet | ☐ Yes | ☐ No |
| Bleeding Disorders | ☐ Yes | ☐ No | High Blood Pressure | ☐ Yes | ☐ No | Swollen Neck Glands | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No | kidney Problems | ☐ Yes | ☐ No | Tired Feet | ☐ Yes | ☐ No |
| Chemical Dependency | ☐ Yes | ☐ No | Liver Disease | ☐ Yes | ☐ No | Tuberculosis | ☐ Yes | ☐ No |
| Chest Pain | ☐ Yes | ☐ No | Low Blood Pressure | ☐ Yes | ☐ No | Ulcers | ☐ Yes | ☐ No |
| Chronic Diarrhea | ☐ Yes | ☐ No | Nervous Problems | ☐ Yes | ☐ No | Varicose Veins | ☐ Yes | ☐ No |
| Circulatory Problems | ☐ Yes | ☐ No | Phlebitis | ☐ Yes | ☐ No | Venereal Disease | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No | Phlebitis | ☐ Yes | ☐ No | Weight Loss, Unexplained | ☐ Yes | ☐ No |
| Ear Problems | ☐ Yes | ☐ No | Psychiatric Care | ☐ Yes | ☐ No | | | |

Surgeries you have had _____

Hospitalization other than for the Surgeries Listed _____

Family Physician _____ Last visit date _____

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

If yes, please explain

## MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

Pharmacy Name(s) _____

Pharmacy phone(s) _____

Do you take oral contraceptives? ☐ Yes ☐ No

## ALLERGIES

| | |
|---|---|
| ☐ Adhesive/Tape | ☐ Local |
| ☐ Anticoagulant | ☐ Anesthetics |
| ☐ Therapy | ☐ Novocaine |
| ☐ Aspirin | ☐ Penicillin |
| ☐ Codeine | ☐ Seafoods |
| ☐ Demerol | ☐ Sulfa |
| ☐ Iodine | |

Other _____

## 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 procedure as may be deemed necessity in the diagnosis and /or treatment of my feet.

Patient's Signature _____ Date _____