Name: ____________________

Date of Birth: ____________ Height: ______ Weight: ______

Email: ____________________

Smoking Status:

- Never smoker
- Former smoker
- Current every day smoker
- Heavy tobacco smoker
- Unknown if ever smoked
- Smoker, status unknown
- Current some day smoker
- Light tobacco smoker

Allergies: ____________________

____

Medications: ____________________

____

____

____

Ethnicity: Hispanic or Latin   Not Hispanic or Latin

Race:

- American Indian/Alaska Native
- Asian
- Black or African American
- White
- Native Hawaiian/Pacific Islander
- Declined to specify

Family Hx

Condition:	Family Member:
Diabetes	______
Hypertension	______
Cancer	______
Vascular Disease	______
Heart Disease	______

flu shot? yes __ no __   pneumonia shot? yes __ no __

Pharmacy: ____________ Location: ____________

Seen By: ____________ PCP: ____________

-------------------------Office Use-------------------------

BP: ______/______ Initials: ____________

Austintown Podiatrv Associates Inc.
Dr. Larry Karlock •Dr. Catherine Karlock •Dr. John Flauto• Dr. Arters •Dr. Darleen Abadco
Austintown (330) 792-6519 · Boardman (330) 729-1200 · Warren (330) 372-1500

PATIENT INFORMATION FORM

Welcome to our practice. Please print out and thoroughly complete (print) the following information.
Bring the completed form to our office at the time of your first visit.

PATIENT INFORMATION

Name: ____________________
Date of Birth: ____________ Age: ____________ Gender: ___ M ___ F
Height: ____________ Weight: ____________
Street Address: ____________________
City/State/Zip: ____________________
Home Phone: ( ) ____________ Cell Phone ( ) ____________
Marital Status: __ Single __ Married __ Divorced __ Widowed
Email: ____________ Website Address: ____________
S.S. Number: ____________ Occupation: ____________
Employer: ____________________
Employer's Address: ____________________
Employer's Phone: ( ) ____________
Spouse's/Parent's Name: ____________________
Spouse's/Parent's Employer: ____________________
Spouse's/Parent's Employer Address/Phone: ____________________
Pharmacy Name ____________________
Pharmacy Location ____________________

INSURANCE INFORMATION **Or check box if card was given at check-in** ☐

Primary Insurance Co: ____________ Insured's Name: ____________
Insured's SS#: ____________ Insured's Group #: ____________
Secondary Insurance Co: ____________ Insured's Name: ____________
Insured's SS#: ____________ Insured's Group #: ____________

BACKGROUND INFORMATION

Family Doctor: ____________ Doctor's Address: ____________
Doctor's Phone: ____________ Last Visit Date: ____________
Emergency Contact Person: ____________________
Emergency Contact Phone: ( ) ____________
How did you hear about our office? ____________________

MEDICAL HISTORY

Briefly describe your present foot problems(s). ____________________
How long have you had problem(s)? ____________________
Any previous treatment(s)? ___ Yes ___ No If yes, briefly describe treatment, by whom, and when?
____
If accident related, give brief description / date occurred. ____________________
Work-related injury Contact person: ____________ Phone: ( ) ____________
Are you / do you plan on filing for Worker's Compensation Benefits? ___ Yes ___ No
Has this been done? ___ Yes ___ No

PATIENT INFORMATION FORM

(Medical History Continued) **PRINT NAME:**____________________

Check any of the following **medical conditions** that you now have, or have had, in the past:

___ AIDS
___ Anemia
___ Anesthetic Complication
___ Arthritis
___ Asthma
___ Bleeding Disorder
___ Bronchitis
___ Cancer
___ Circulation Problems

___ Diabetes (If so, how long?) ______
___ Emphysema
___ Epilepsy/Seizures
___ Glaucoma
___ Gout
___ Heart Disease
___ Heart Murmur
___ Hepatitis
___ High Blood Pressure

___ High Cholesterol
___ HIV
___ Kidney Disease
___ Liver Disease
___ Muscular Disorder(s)
___ Phlebitis / Blood Clots
___ Polio / Cerebral Palsy
___ Rheumatoid Arthritis
___ Rheumatic Fever

___ Sexually Transmitted Disease
___ Shortness of Breath
___ Stomach Ulcers
___ Stroke
___ Swelling of Ankles / Feet
___ Thyroid Problems
___ Tuberculosis
___ Varicose Veins
___ Wound Healing Problems

List any **other medical conditions:** ____________________
List any medical problems that run in your **immediate family:** ____________________
List any **medications** you are taking: ____________________
____

Please check any **allergies** you have: ___ Adhesives ___ Codeine ___ Iodine ___ Sulfa
___ No known allergies ___ Anesthetics ___ Penicillin ___ Other:

Do you **smoke**? ___ Yes ___ No How much? ____________________
Do you drink **alcohol**? ___ Socially ___ Regularly ___ No

Do you have a family history of (**Y** or **N**): ___ Diabetes ___ Hypertension ___ Cancer
___ Vascular Problems ___ Heart Problems

Please list any previous **surgeries** with date, type of anesthesia, and any complications. ____________________
____

Please list any non-surgical **hospitalizations** and date(s). ____________________
____

Please give any **other** pertinent medical history. ____________________
____

I hereby give Austintown Podiatry Associates Inc. permission to examine and administer treatment, after consultation, and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition. I also assign to Austintown Podiatry Associates Inc. all payment for medical services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by my insurance carrier. I also authorize release of medical information necessary to process any health insurance claims. A copy of my signature on file will be considered as valid as the original.

X____________________ Date: X____________________

Signature of Patient / Parent / Guardian

Consent for care: I hereby give my consent for treatment to Austintown Podiatry Associates (Drs. Lawrence and Catherine Karlock, Dr. John Flauto, Dr. Joseph Arters, and Dr. Darleen Abadco) including treatment or services, and which may include but not limited to examination, x-rays, injections, photos and treatments which my physicians and I agree are necessary.

Authorization to Obtain/Release Medical Records: I authorize Austintown Podiatry Associates, or any person designated by them to obtain/release copies of my medical records to any physician or institution for the purpose of evaluation and/or comparison with examination and testing being performed on me/my dependent.

Authorization to Pay Benefits to Physicians: I hereby authorize payment to Austintown Podiatry Associates for services rendered to me or my dependents. I also authorize this office to release any information necessary to expedite insurance claims. To the extent permitted by law I authorize holder to release information to CMS and applicable other government agencies in regards to determine benefits for service. **I understand that I am responsible for any balance not covered by insurance and or collection costs and legal fees incurred in any attempt to collect said balance.** I assign all medical and surgical benefits to Austintown Podiatry Associates.

Authorization to Leave Message: I hereby authorize Austintown Podiatry Associates to leave message regarding pending appointments and/or tests at my residence. You may notify me of lab/test results, matters relating to prescriptions, etc. by leaving a message (check all that apply) ___ on my answering machine/home voicemail: ____ with my spouse:____ with a family member (please specify the name of family member) ________________________________

I have been given an opportunity to read the Health Information Portability & Accountability Act of 1996 (HIPAA)

Patient's Name (please print): X____

Signature: X____ Date: X__________