

Austintown Podiatry Associates Inc.

Name: _____

Date of Birth: _____ Height: _____ Weight: _____

Email: _____

Do you smoke? ___ Yes ___ No

If yes, how long? _____

Medication Allergies: _____

Current Medications: _____

Pharmacy Name and Location: _____

Family Doctor: _____

Austintown Podiatry Associates Inc.
Dr. Lawrence Karlock - Dr. Catherine Karlock
Dr. Darleen Abadco - Dr. Daniel Bullard

Austintown (330)792-6519 - Boardman (330)729-1200 - Warren (330)372-1500

● **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: _____
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 and Location: _____

● **INSURANCE INFORMATION or check line if 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: _____ Address: _____
Phone Number: _____ Date last seen: _____
Emergency Contact Person: _____
Emergency Contact Phone: _____
How did you hear about our office? _____

● **MEDICAL HISTORY**

Briefly describe your present foot problem(s). _____

How long have you had problem(s)? _____

Any previous treatment(s)? Yes No If yes describe treatment, by whom, and when?

If accident related, give a 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:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Diabetes
(If so, how long?) _____ | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sexually Transmitted disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> HIV | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Anesthetic Complication | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Muscular Disorder(s) | <input type="checkbox"/> Swelling of Ankles |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Phlebitis / Blood Clots | <input type="checkbox"/> /Feet |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Polio / Cerebral Palsy | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Wound Healing Problems |
| | | <input type="checkbox"/> Tuberculosis | |

List any **other medical condition**: _____

List any medical problems that run in your **immediate family**: _____

List any **medications** you are taking: _____

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

Do you **smoke**? Yes No If, yes 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 preform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition. I also assign the 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.

Signature of Patient/Parent/Guardian: _____ Date: _____

Consent for care: I hereby give consent for treatment to Austintown Podiatry Associates (Drs. Lawrence and Catherine Karlock, Dr. Darleen Abadco, and Dr. Daniel Bullard) 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 hereby 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 preformed 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 voice messages 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 1966 (HIPAA)

Patient's Name (please print): _____

Signature of Patient/Parent/Guardian: _____