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

• 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

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

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

__Aids
__**Diabetes (If so, how long?)**_____
__High Cholesterol
__Sexually Transmitted disease
__Anemia
__Anesthetic Complication
__Emphysema
__HIV
__Shortness of Breath
__Arthritis
__Epilepsy/Seizures
__Kidney Disease
__Stomach Ulcer
__Asthma
__Glaucoma
__Liver Disease
__Stroke
__Bleeding Disorder
__Gout
__Muscular Disorder(s)
__Swelling of Ankles /Feet
__Phlebitis / Blood Clots
__Bronchitis
__Heart Disease
__Polio / Cerebral Palsy
__Thyroid Problems
__Cancer
__Heart Murmur
__Rheumatoid Arthritis
__Varicose Veins
__Hepatitis
__Rheumatic Fever
__Wound Healing Problems
__Circulation Problems
__High Blood Pressure
__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 perform 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 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 holders 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:_____Date: _____