

Podiatry

ETMC First Physicians

Dr. Thomas F. McCloskey

Patient Registration and Information Form

PLEASE PRINT

Name _____ Birthdate _____

Social Security # ____ - ____ - ____ Driver's License # _____ Age: ____ male ____ female ____

Mailing Address _____ City _____ St. _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Marital Status _____ Email Address _____

Patient's Employer _____ Work Phone _____

Were you injured at work? Yes ____ No ____ If yes, explain _____

Referring Physician _____ Former Podiatrist _____

Emergency contact _____ Contact Phone: _____

Race Choices : ____ White ____ Asian ____ Black ____ Hispanic ____ American Indian ____ Other ____ Unknown

Ethnic Coices: ____ Hispanic ____ Non-Hispanic ____ Other

INSURANCE INFORMATION

PRIMARY INS. _____ **SECONDARY INS.** _____

(please give insurance cards to receptionist)

Insured's Information (To be completed only if different from patient)

Name of Insured Person: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Insured's Social Security #: _____

Insured's Employer: _____ Employer Phone: _____

Patient Information Form

What is your **main complaint** with your feet? _____

Describe your pain: burning____ tingling____ throbbing____ sharp____ numb____ other_____

How long has it bothered you? _____

Did it begin: gradually ____ or suddenly ____

Have you received treatment for this in the past? Yes ____ No ____

If yes, what treatment was received? _____

Please list all medications you currently take: (If you have a medication list, please give to receptionist)

Drug Allergies No ___ Yes ___ (List)

Preferred PHARMACY (List)

Height _____ Weight _____ Shoe Size _____

If Diabetic, last blood sugar reading _____ When was it last taken _____

Social History

Do you smoke? Yes ____ No ____ Number of packs per day _____

Previously smoked? Yes ____ No ____ Number of years smoked _____

Do you drink alcohol? Yes ____ No ____ If yes, how much? _____

Do you consume caffeinated products? Yes ____ No ____ If yes, what kind? _____

Family History

Has any family members had: Circle Answer if it applies

Diabetes Peripheral Arterial Disease (PAD) Stroke Heart Problems

Problems with Scars Rheumatoid Arthritis Other (explain) _____

Review of Systems

Are you currently having problems with or being treated for the following? (INDICATE YES or NO)

Constitutional	<i>Circle One</i>		Respiratory	<i>Circle One</i>	
Fever	Yes	No	Chronic cough	Yes	No
Migraines	Yes	No	Shortness of breath	Yes	No
Weight loss/gain	Yes	No	Pneumonia	Yes	No
Night sweats	Yes	No	Lung cancer	Yes	No
			Bloody sputum	Yes	No
Eyes			Asthma	Yes	No
Infections	Yes	No	C.O.P.D.	Yes	No
Blurred Vision	Yes	No			
Glaucoma	Yes	No	Gastrointestinal		
Cataracts	Yes	No	Indigestion or pain	Yes	No
Macular degeneration	Yes	No	Nausea/Vomiting	Yes	No
			Liver disease/Hepatitis	Yes	No
Ear, Nose, Throat and Mouth			Jaundice	Yes	No
Hearing loss	Yes	No	Colon cancer	Yes	No
Ringing in ears	Yes	No			
Balance disturbance	Yes	No	Genitourinary		
Nosebleeds	Yes	No	Urinary tract infections	Yes	No
			Painful urination	Yes	No
Cardiovascular			Blood in your urine	Yes	No
Heart murmur/Mitral valve prolapse	Yes	No	Kidney	Yes	No
Swelling in feet or ankles	Yes	No	Frequent urination	Yes	No
Leg pain/cramp/walking	Yes	No	Dialysis	Yes	No
Leg pain/cramp/resting	Yes	No	Male: Prostate cancer	Yes	No
Heart attack	Yes	No			
High blood pressure	Yes	No	Musculoskeletal		
Chest pain	Yes	No	Broken bones	Yes	No
Stroke	Yes	No	Arm or leg weakness	Yes	No
			Back pain	Yes	No
			Arm or leg pain	Yes	No
			Joint pain or swelling	Yes	No
			Arthritis	Yes	No

Have you been in the **hospital** within last year? _____

Review of Systems (Continued)

List **ALL** previous surgeries and the approximate date(s): _____

Are you currently having problems with or being treated for the following? (INDICATE YES or NO)

Skin Disorders

Circle One

New growths	Yes	No
Color change of mole/wart	Yes	No
Skin cancer	Yes	No
Hives	Yes	No
Psoriasis	Yes	No
Eczema	Yes	No
Scarring tendencies/Keloid formation	Yes	No

Endocrine

Circle One

Increased appetite	Yes	No
Excessive thirst or urination	Yes	No
Hormone problems	Yes	No
Thyroid problems	Yes	No
Gout	Yes	No
Diabetes	Yes	No

Neurological

Fainting spells or blacking out	Yes	No
Seizures	Yes	No
Disorientation	Yes	No
Difficulty with your speech	Yes	No
Double or blurred vision	Yes	No
Loss of coordination	Yes	No
Burning/tingling/numbness in feet	Yes	No

Hematologic/Lymphatic

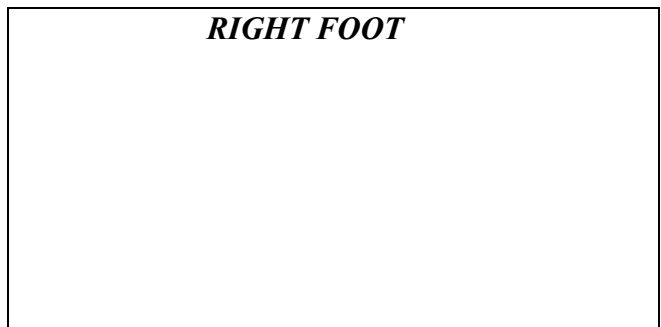
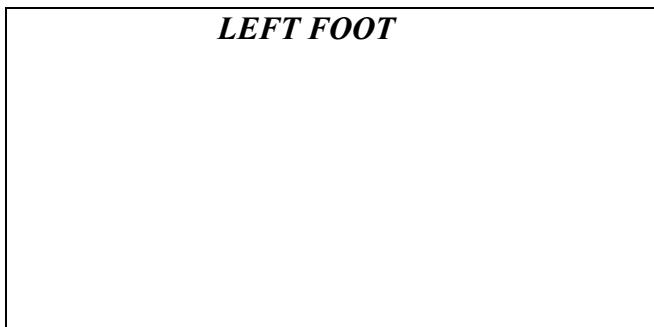
Anemia	Yes	No
Bleeding tendencies	Yes	No
Persistent swollen glands/lymph nodes	Yes	No
Blood transfusion	Yes	No
Other illnesses or problems	Yes	No
If so, please state _____		

Psychiatric

Anxiety	Yes	No
Depression	Yes	No
Other psychiatric disorder/treatment	Yes	No

For women, are you pregnant Yes No
If so, how many months _____

On the diagram below, please mark the place(s) where you are experiencing pain in your feet



Assignment of Benefits

I hereby authorize direct payment of medical/surgical benefits to ETMC Physicians for services rendered by Dr. Thomas F. McCloskey in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance. Failure to pay this balance may result in use of a collection agency.

Medicare Patients

Medicare will only pay for services that their regulations deem to be “reasonable and necessary”. This does not always coincide with the opinion of the physician or the American Podiatric Medical Association. If Medicare determines a particular service is not considered necessary, they will not pay for it. By law, we are required to inform you that Medicare will not agree to pay for the following services:

- *Cutting of nails, corns, calluses without a systemic qualification are NOT covered by Medicare. New patient visits to determine these conditions are usually covered by Medicare***
- *Devices such as post op shoes, cam walkers and other such products are ONLY covered by Medicare on a case by case decision by our local Medicare carrier***

All Patients

*I authorize the holder of medical or other information to release to my insurance carrier, governmental agency, or its intermediary, any information needed for this or a related insurance claim. **I agree to pay any charges incurred by me to ETMC PHYSICIANS CLINIC.***

I have been notified of the above information and I agree to be personally and fully responsible for payment. This office is committed to be in compliance with all federal and state practice and billing regulations.

Signature (Parent, if patient is a minor)

Date