

**PETER C SMITH, DPM**

**DIPLOMATE, AMERICAN BOARD of FOOT and ANKLE SURGERY**

**NEW PATIENT INFORMATION FORM**

1. NAME: (MR., Mrs., Ms.) \_\_\_\_\_ DOB: \_\_\_\_\_
2. ADDRESS: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_
3. PHONE: \_\_\_\_\_ Cell: \_\_\_\_\_ Emergency: \_\_\_\_\_
4. EMAIL: \_\_\_\_\_
5. MEDICAL DOCTOR: \_\_\_\_\_ LAST VISIT: \_\_\_\_\_
6. PHARMACY: \_\_\_\_\_
7. EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_
8. MARRIED: Y N SPOUSE NAME: \_\_\_\_\_
9. HOW DID YOU HEAR ABOUT OFFICE/WHO REFER YOU: GOOGLE INTERNET FACEBOOK  
FRIEND/FAMILY \_\_\_\_\_ DOCTOR OFFICE \_\_\_\_\_

**INSURANCE INFO**

**PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD AND PHOTO ID**

1. PRIMARY INS SUBSCRIBER: \_\_\_\_\_ DOB: \_\_\_\_\_
  2. RELATION TO SUBSCRIBER: \_\_\_\_\_
  3. SECONADRAY INS: \_\_\_\_\_
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**CONSENT TO TREAT**

I give Peter C Smith, DPM permission to examine and treat my feet, ankles and lower extremities, medically, orthopedically or surgically as he deems fit after he has thoroughly discussed this with me including the Alternatives, Risks and Complications of said treatment. I also give him permission to perform minor surgical procedures as may be deemed necessary for the treatment of my condition again after discussing the Alternatives, Risks, and Complications.

**ASSIGNMENT of BENEFITS**

I authorize Dr. Peter C Smith to bill my insurance company and for the insurance company to pay him directly for my medical and surgical claims. I also authorize the release of any information to my insurance company necessary to process the claims.

**MEDICARE PATIENTS**

I authorize that the payment of Medicare/Medigap/Medicare Advantage benefits be made either to me or on my behalf to the name of provider of service and/or supplier for any services furnished to me by that provider of service and/or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and it's agents any information needed to determine these benefits or the benefits payable to the related service.

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_

PARENT or LEGAL GUARDIAN or POA: \_\_\_\_\_

## CURRENT FOOT/ANKLE PROBLEM

1. Describe present problem: \_\_\_\_\_
2. When did it start? \_\_\_\_\_
3. What make it worse? \_\_\_\_\_
4. Have you seen a Podiatrist before, if so when? \_\_\_\_\_
5. ARE YOU UNDER HOSPICE CARE? \_\_\_\_\_  
*OFFICE USE ONLY: ABN (Yes NO)*

## PAST MEDICAL HISTORY

- 1 List all allergies: \_\_\_\_\_
2. Current medications you take: \_\_\_\_\_  
\_\_\_\_\_
3. Are you currently seeing your physician on a regular basis? \_\_\_\_\_
4. Do you have or have you had any of the following:

_____ Diabetes T1 or T2	_____ HTN/BP	_____ Heart Surgery
_____ Mitral Valve	_____ Heart disease	_____ PVD/PAD
_____ Varicose Veins	_____ Phlebitis/DVT	_____ Anemia
_____ Epilepsy/Seizures	_____ Reflux/Stomach Dx	_____ Neuropathy
_____ Autoimmune Dx	_____ Scarlet Fever	_____ Artificial Joint
_____ Liver Disease	_____ Hepatitis	_____ Lung Disease
_____ Tuberculosis	_____ Asthma	_____ Kidney Disorders
_____ Cancer	_____ Gout	_____ Arthritis
_____ Thyroid Condition	_____ Scarring Tendency	
6. Other Conditions: \_\_\_\_\_  
\_\_\_\_\_
7. Past Surgeries: \_\_\_\_\_
8. If female: Are you pregnant? \_\_\_\_\_
9. Family History: \_\_\_\_\_ Diabetes \_\_\_\_\_ Heart Disease \_\_\_\_\_ Stroke  
\_\_\_\_\_ HTN \_\_\_\_\_ Cancer \_\_\_\_\_ Arthritis \_\_\_\_\_ Other
10. Do you: \_\_\_\_\_ Smoke \_\_\_\_\_ppd \_\_\_\_\_yrs? Drink coffee/tea: \_\_\_\_\_  
\_\_\_\_\_ Drink alcohol
11. Exercise/Fitness Routine (miles/days per week/ how long etc): \_\_\_\_\_  
\_\_\_\_\_
12. Type of work: \_\_\_\_\_ How long at present job? \_\_\_\_\_
13. Type of shoes worn most often: \_\_\_\_\_