PODIATRY CENTER OF EASTERN CT, LLC

360 Tolland Turnpike
Manchester, CT 06042
(860) 647-7727

Last Name_____ First Name_____ MI_____

Address_____ City_____State_____ Zip_____

Sex_____ Date of Birth_____ Age_____ SSN_____

Home Phone_____ Cell/Work Phone_____ Marital Status_____

Employer Name/Address_____ Occupation_____

Shoe Size_____ Height_____ Weight_____ Pharmacy Name/Address_____

Primary Care Doctor Name/Address_____

Referred by_____

MEDICAL HISTORY:

Reason for Visit_____

Right Foot_____ Left Foot_____ How long has this been a problem?_____

Do you have Diabetes? Yes____ No____ Do you use Insulin? Yes____ No____

Do you have any Artificial Joints? Yes____ No____ If Yes, Location/Year of Surgery_____

Do you Smoke? Yes____ No____ If Yes, # of packs per day_____ Do you Drink Alcohol? Yes____ No____

Employment: Sit____ Stand____ Stand & Walk____

LIST ANY ALLERGIES_____

LIST YOUR MEDICATIONS_____

_____

CIRCLE CURRENT MEDICAL CONDITIONS: ASTHMA CANCER HEART DISEASE/BYPASS HIGH BLOOD PRESSURE MRSA BLOOD CLOTS PARKINSONS BLEEDING DISORDERS KIDNEY DISEASE RHEUMATOID ARTHRITIS OTHER_____

Name/Phone # of Emergency Contact_____Relationship_____

_____(Initial) I request that payment of the authorized benefits be made either to me, or Podiatry Center of Eastern CT, LLC on my behalf, for any services furnished to me by that physician. I authorize any holder of medical information about me to release to my insurance company and its agents, or any supplier of medical benefits, any information needed to determine those benefits, or the benefits payable to related services.

_____(Initial) I hereby give my permission to have my feet examined and treated. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I will notify you of any change in health status, or in any of the above information, which is true to the best of my knowledge.

_____(Initial) I have been offered a copy of the Privacy Policy that Podiatry Center of Eastern CT, LLC follows as mandated by HIPAA (Health Insurance Portability and Accountability Act).

Patient(or Representative) Signature_____ Date_____