ADVANCED PODIATRY™
Physicians and Surgeons of the Foot and Ankle

HOWLAND CORNERS
8345 East Market Street
Warren, Ohio 44484
Phone: (330) 856-2915
Fax: (330) 856-2956

CORTLAND
251 South High Street
Cortland, Ohio 44410
Phone: (330) 637-2915
Fax: (330) 638-2081

CHAMPION PLAZA
4441 Mahoning Avenue
Warren, Ohio 44483
Phone: (330) 847-8892
Fax: (330) 847-2006

AUSTINTOWN
1570 S. Canfield Niles Rd.
Youngstown, Ohio 44515
Phone: (330) 270-0900
Fax: (330) 270-5680

COLUMBIANA
21 North Main Street
Columbiana, Ohio 44408
Phone: (330) 482-2161
Fax: (330) 482-1770

Reviewed By: _____

PATIENT INFORMATION SHEET

Please give your insurance card to the receptionist to make a copy for your file.

Patient Last Name: _____ First: _____ Middle Initial: _____
Address:_____ City: _____ State: _____ Zip: _____
Cell Phone #: (_____) _____-_____ Alternate Phone #: (_____) _____-_____
Date of Birth: _____/_____/_____ Sex: □ Male □ Female Marital Status: □ Single □ Married □ Divorced
Social Security #: _____-_____- _____ Patient's Employer: _____
Occupation (Indicate if Student): _____ Work #: (_____) _____-_____
Spouse or Parent's Name: _____ Employer: _____

Primary Insurance: _____ Date of Birth of the Insured: ____/_____/_____
Name of Insured: _____ Relationship to Patient: □ Self □ Spouse □ Parent/Guardian
Insured's Address: _____ City: _____ State: _____ Zip: _____
Policy # or ID#: _____ Group #: _____
Secondary Insurance: _____ Date of Birth of the Insured: _____/_____/____
Name of Insured: _____ Relationship to Patient: □ Self □ Spouse □ Parent/Guardian
Insured's Address: ___ _____ City: _____ State: _____ Zip: _____
Policy # or ID#: _____ Group #: _____
Person Responsible for Payment: _____ Employer: _____

Who is your personal or **Family Physician**? _____ Phone #: (_____) _____-_____
What is your preferred **Pharmacy**? _____ Location: _____

Please check any **Allergies** to medications that apply: □ **No Known Allergies to Medications**
□ Penicillin □ Codeine □ Aspirin □ Sulfa □ Steroid □ Other:_____

Have you ever been a **Patient** in our office? □ Yes □ No Approximate year of treatment? _____
If Yes, what was your Name then? □ Same Other: _____

Who can we thank for **referring** you to us? _____ Relationship: _____
□ Google □ Website □ Tribune □ Vindicator □ Champion Times □ Cortland News Other: _____

Emergency Contact: Please list the name of a relative or friend that we may contact in case of an emergency.
Name: _____ Relationship: _____ Cell Phone: (_____)_____-_____

ASSIGNMENT OF BENEFITS

I hereby instruct and direct my insurance company to pay and mail direct to Advanced Podiatry™ the professional and medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by Advanced Podiatry™.

I hereby authorize release of medical information as may be necessary to the insurance carrier for the completion of any medical claims incurred as a patient of Advanced Podiatry™ I hereby give permission to the physicians of Advanced Podiatry™ to treat my feet and/or ankles.

This document shall serve as my signature on file from this date forward for any treatment performed by the physicians of Advanced Podiatry™.

_____ _____ _____/_____/_____

Signature of Patient or Authorized Person (if Minor or Power of Attorney) *Relationship of Authorized Person* **Date**

PERSONAL HEALTH HISTORY

*Please **check** and **explain** where needed any medical **condition** which you now have and **list** any **medications** you are taking for that condition.*

YES	NO	CONDITION	MEDICATION	YES	NO	CONDITION	TYPE	MEDICATION
☐	☐	Gout	_____	☐	☐	Cancer	_____	_____
☐	☐	Asthma	_____	☐	☐	Anemia	_____	_____
☐	☐	Arthritis	_____	☐	☐	Hepatitis	_____	_____
☐	☐	Diabetes	_____	☐	☐	Lung Disease	_____	_____
☐	☐	Epilepsy	_____	☐	☐	Heart Problem	_____	_____
☐	☐	HIV	_____	☐	☐	Kidney Disease	_____	_____
☐	☐	Glaucoma	_____	☐	☐	Nerve Disorder	_____	_____
☐	☐	Depression	_____	☐	☐	Muscle Disorder	_____	_____
☐	☐	Low Thyroid	_____	☐	☐	Healing Problem	_____	_____
☐	☐	Varicose Veins	_____	☐	☐	Bleeding/Clotting	_____	_____
☐	☐	Water Retention	_____	☐	☐	Circulation Problem	_____	_____
☐	☐	Rheumatic Fever	_____	☐	☐	Chemical Dependent	_____	_____
☐	☐	High Cholesterol	_____	☐	☐	Stomach/GI Disorder	_____	_____
☐	☐	High Blood Pressure	_____	☐	☐	Other	_____	_____

Patient Age: _____

GENERAL MEDICAL INFORMATION:

*Please **Check** any that apply.*

Are you **Pregnant** or planning to be in the future? ☐ YES ☐ NO ☐ Not Applicable
Are you presently taking **Birth Control** medication? ☐ YES ☐ NO ☐ Not Applicable
Have you had **Oral Steroids** in the past six (6) months? ☐ YES ☐ NO
Have you had **General** Anesthesia, i.e., "gone to sleep"? ☐ YES ☐ NO Any Problems? ☐ YES ☐ NO What?_____
Have you had **Local** Anesthesia, such as at the dentist? ☐ YES ☐ NO Any Problems? ☐ YES ☐ NO What?_____
Who is your **Personal** or **Family Physician**?_____

SURGERY HISTORY:

Have you ever had **Surgery?** ☐ YES ☐ NO *If **YES,** please **List** below with your best estimate of Month and Year.*

SURGERY	MONTH/YEAR	SURGERY	MONTH/YEAR	SURGERY	MONTH/YEAR
_____	_____/_____	_____	_____/_____	_____	_____/_____

HOSPITALIZATION HISTORY:

Have you ever been **Hospitalized** with an **Illness**? ☐ YES ☐ NO *If **YES,** please **List** below with your best estimate of Month and Year.*

HOSPITALIZED ILLNESS	MONTH/YEAR	HOSPITALIZED ILLNESS	MONTH/YEAR	HOSPITALIZED ILLNESS	MONTH/YEAR
_____	_____/_____	_____	_____/_____	_____	_____/_____

FAMILY HEALTH HISTORY: *Please **Check** any that apply.* ☐ **No Known Family Health Problems**

CONDITION	WHAT FAMILY MEMBER	CONDITION	WHAT FAMILY MEMBER	CONDITION	WHAT FAMILY MEMBER
☐ Diabetes	_____	☐ Heart Disease	_____	☐Cancer/Type:_____	_____
☐ Stroke	_____	☐ High Blood Pressure	_____	☐Other: _____	_____

SOCIAL HISTORY: *Please **Check** any that apply and relate **Frequency**.*

Do you **Smoke**? ☐ YES ☐ NO If YES, how much? _____ ☐ Cigarettes ☐ Packs / Day
Do you **Drink** Alcohol? ☐ YES ☐ NO If YES, how much? _____ Alcohol Drink(s) / Week
Do you take Recreational **Drugs**? ☐ YES ☐ NO If YES, what Recreational Drug(s)?_____

ALLERGIES: *Please **Check** any that apply.* ☐ **No Known Allergies to Medications**

☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Steroid ☐ Environmental (Pollen, dust, etc.)
☐ Novocain ☐ Aspirin ☐ Tape ☐ Metal ☐ Other: _____
If you had an **Allergic Reaction**, what were your Symptoms? ☐ Hives ☐ Rash ☐ Difficulty breathing

REASON FOR TODAY'S APPOINTMENT

☐ **Right Foot**: ☐ Ankle Pain ☐ Heel Pain ☐ Arch Pain ☐ Ball Pain ☐ Great Toe Pain ☐ Lesser Toe Pain ☐ Nail Pain ☐ Fungus
☐ Other:_____
☐ **Left Foot**: ☐ Ankle Pain ☐ Heel Pain ☐ Arch Pain ☐ Ball Pain ☐ Great Toe Pain ☐ Lesser Toe Pain ☐ Nail Pain ☐ Fungus
☐ Other:_____
How **Long** have you had the **Problem**? #____**:** ☐ Days ☐ Weeks ☐ Months ☐ Years Is the Problem getting **Worse**? ☐ YES ☐ NO
Have you **Tried** anything to **Improve** your condition? ☐ YES ☐ NO If YES, **What** have you tried? *Please **check** any that apply*
☐ Advil or Aleve ☐ Ice ☐ Soaking ☐ Neosporin ☐ Different Shoes ☐ Nail Antifungal ☐ Wart Medication
☐ Decrease Activity ☐ Pads ☐ Stretching ☐ Arch Supports ☐ Custom Orthotics Other: _____
Have you had Foot Treatment **Before**? ☐ YES ☐ NO If YES, by **Whom**? Dr._____ If YES, about what **Year**?
If YES, for **What**? ☐ Ankle Pain ☐ Heel Pain ☐ Arch Pain ☐ Ball Pain ☐ Great Toe Pain ☐ Lesser Toe Pain ☐ Nail Pain ☐ Fungus
☐ Other:_____

I hereby give permission to the physicians and medical personnel of Advanced Podiatry™ to examine and treat my feet.

_____ _____ _____ _____/_____/_____
Signature of Patient or Authorized Person (if Minor or Power of Attorney) *Relationship of Authorized Person* **Reviewed By** **Date**