Welcome to Lodi Podiatry

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you and maintaining your health.

Patient Information

Name ______________________________ Soc. Sec.# ______________
Last Name First Name Initial

Phone No. ______________ Cell Phone No. ______________

Mailing Address ______________ Email ______________

City ______________ State ______ Zip ______

Sex ☐ M ☐ F Age ______ Birthdate ______ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Race: Please check one ❍ American Indian or Alaska Native ❍ Asian ❍ Black or African American ❍ Hispanic ❍ Native Hawaiian or Other Pacific Island ❍ White ❍ Not Specified

Spouse or Guardian Name ______________

Patient Employed by ______________ Occupation ______________

Business Address ______________ Business Phone ______________

Who may we thank for referring you? ______________

Family Doctor ______________

Notify in case of emergency ______________ Home Phone ______ Work Phone ______
(Does not reside with you)

Primary Insurance

Person Responsible for Account ______________
Last Name First Name Inital

Relation to Patient ______________ Birth Date ______ Soc. Sec.# ______

Address ______________ Phone ______________

City ______________ State ______ Zip ______

Insurance Company ______________ Phone ______________

Subscriber # ______________ Group # ______________

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______________ Relation to Patient ______ Birth Date ______

Address (if different from patient) ______________ Soc. Sec.# ______

City ______________ State ______ Zip ______ Phone ______

Subscriber Employed by ______________ Business Phone ______________

Insurance Company ______________ Phone ______________

Subscriber # ______________ Group # ______________

Please complete both sides.

Patient Podiatric and Health Information

Family Physician ______________________ Last Visit ______________

What is the nature of your foot problem? ______________________

Height ____________ Weight ____________ Shoe Size ____________

Do you have back pain? Y☐ N☐ Have you had previous foot/ankle surgery? Y☐ N☐ Date & Type ____________

Do you use tobacco products? Y ☐ N ☐ If yes, what amount daily? ____________

Medical History

Check (✓) if you have had any of the following:

- ☐ Aids/HIV
- ☐ Arthritis, Rheumatisim
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Circulatory problems
- ☐ Cramps/Numbness in feet or legs
- ☐ Diabetes
- ☐ Gout
- ☐ Heart trouble
- ☐ Hepatitis or Jaundice
- ☐ High blood pressure
- ☐ History of drug abuse
- ☐ Kidney trouble
- ☐ Liver trouble
- ☐ Respiratory Disease
- ☐ Shortness of Breath
- ☐ Swelling of feet or ankles
- ☐ Transfusions
- ☐ Varicose veins
- ☐ Pacemaker

Are you allergic or sensitive to:

- ☐ None
- ☐ Adhesive Tape
- ☐ Anticoagulant Therapy
- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Iodine
- ☐ Local Anesthetics
- ☐ Novocaine
- ☐ Penicillin
- ☐ Seafoods
- ☐ Sulfa
- ☐ Other ____________

List medications you are currently taking, if any, including vitamins or herbs:

______________________ ______________________

______________________ ______________________

______________________ ______________________

Pharmacy Name ______________________ Phone Number ____________

Do you take oral contraceptives? ☐ Y ☐ N

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

I authorize my insurance company to pay to Thomas G. Shock, DPM or Kevin I. Stroh, DPM all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature ______________________ Date ____________

Medicare Signature on File

I request that payment at authorized Medicare benefits be made on my behalf to Thomas G. Shock, DPM or Kevin I. Stroh, DPM for any services furnished me by the listed Physician/Supplier I authorize any holder of Medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the below named Medigap Insurer any information needed to determine benefits payable for services from this provider.

I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim If "other health insurance" to indicated in Block 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes realeasing of the information to the insurer of agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare Carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare Carrier.

Beneficiary Signature ______________________ Date ____________

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

____ _______________________
Patient Name (please print) Date

____
Parent or Authorized Representative (if applicable)

____
Signature