MELBOURNE PODIATRY ASSOCIATES

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name:(First)_____(Last)_____

DOB:_____Social Security No:_____

Street Address:_____

City:_____State:_____Zip Code:_____

Primary Phone:_____Secondary Phone:_____

Email Address:_____

Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian

☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline

Ethnicity (please select): ☐ Hispanic or Latino Hispanic ☐ Not Hispanic or Latino ☐ Decline

Employer Name:_____Work Number:_____

Is this a worker's Comp Claim? ☐ Yes or ☐ NO Date of Injury:_____

Primary Heath Insurance Name:_____

Secondary Health Insurance Name:_____

Insurance Responsibility/Release of Information

I understand and agree that regardless of my insurance status, I am financially responsible for the balance of my account. I acknowledge that I am responsible for any deductible, co-pay, or other balance not covered by the insurance carrier(s). Co-pays & deductibles are due at time of service. I hereby authorize any treatment(s), agreed upon with Dr. Richard Wilson, Dr. Jared Moyles, Dr. Thomas Wilson, and/or Dr. Jessica Wilson which may be deemed advisable. I hereby authorize payment directly to Melbourne Podiatry Associates for services. I understand that I must provide a legible copy of my insurance card. I hereby authorize Melbourne Podiatry Associates to release full details of my medical history for the purpose of healthcare management and/or processing all medical claims on my behalf. I authorize Melbourne Podiatry Associates to release any information acquired during my treatment necessary to process claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignments. I authorize text messages to be sent to my mobile phone. I understand that my doctor has a financial interest in the use of a software platform provided by EBM Medical. I also acknowledge that I have been offered the "Notice of Privacy Practices" for Melbourne Podiatry Associates and can review the notice upon request.

Patient/Guardian Signature:_____Date:_____

MPA MELBOURNE PODIATRY ASSOCIATES

Pharmacy Name:_____

Location(Cross Streets):_____

Who is your Primary Care Doctor:_____

Date of the last time you saw them:_____

EMERGENCY CONTACT/HIPPAA

In case of emergency, who should we contact on your behalf? Do you give our office and the doctors at Melbourne Podiatry Associates permission to discuss your medical condition and information about your care with the family member or close friends below?

Name: _____Phone: _____Relationship: _____

I give permission to discuss medical condition/information ☐ YES or ☐ NO

Name: _____Phone: _____Relationship: _____

I give permission to discuss medical condition/information ☐ YES or ☐ NO

Advance Directive

Do you have a living will or advance directive? ☐ YES OR ☐ NO

If yes, specify below who has medical power of attorney for your affairs

Name:_____Relationship:_____

If yes, does this document specify any limitations of care in the event of an emergency. If so, please document below.

Limitations:_____

NAME:_____ **DOB:**_____

How did you hear about our office?_____

1.What is your main foot problem today? _____

_____

How severe is the pain or problem (circle) **1 2 3 4 5 6 7 8 9** How long have you had the pain _____

When is the problem worse? (circle) **first out of bed AM PM during/after work all day**

How would you describe the pain? (circle) **shooting burning aching throbbing sharp dull tingling numbness tender to touch other**_____

What makes the pain better? _____

What makes it worse or causes the pain? _____

How has it been treated (circle) **ice rest pads Advil Tylenol Other**_____

Do you have any other foot problems that need attention_____

2. Do you have diabetes? ☐ **Yes or** ☐ **NO** If no skip to question 3.

How long?_____ Treating Physician:_____

Average Blood Sugar:_____ Hemoglobin A1C:_____

Are you on (check all that apply) ☐ **oral medication** ☐ **insulin** ☐ **diet**

3. Allergies: ☐ **No Known Drug Allergies** ☐ **penicillin** ☐ **sulfur** ☐ **iodine** ☐ **latex** ☐ **aspirin**

☐ **codeine** ☐ **Novocaine** ☐ **epinephrine other:**_____

4.List all major surgeries or hospitalization: _____

_____

5. List all major injuries and illnesses: _____

_____

6. List all medication: _____

_____

_____

7. Do you smoke? ☐ **Never** ☐ **Former** ☐ **Current** If yes, How many per day?_____

8. Do you Drink Alcohol? ☐**Never** ☐ **Occasionally** ☐ **2-3 per/month** ☐ **2-3 per/week** ☐ **4 or more per week**

9. Do you exercise regularly? ☐ **Yes or** ☐ **No** If yes, how much per week?_____

10. For women: Are you , or could you be pregnant? ☐ **Yes or** ☐ **No** If yes, number of months_____

Please check any disease and/or condition that you are on medication for, any symptoms that you currently have or had in the past and/or anything that you have been diagnosed with.

	Yes	When		Yes	When		Yes	When
Anemia			Heart Surgery			Sleeping difficulty		
Artificial Valve			High blood pressure			Stomach trouble		
Back Pain			HIV +			Stomach ulcers		
Bad leg circulation			Impaired Sight			Stroke		
Bleeding Disorder			Keloid Scars			Thyroid		
Blood clot in legs			Kidney Disease			Tingling		
Brain Disease			Kidney Stones			Varicose veins		
Bypass Surgery legs			Leg Cramps			Weakness		
Chemotherapy			Leg Pain/Walking			Weight Gain		
Chest pain			Liver Problems			Weight Loss		
Cholesterol			Lung Problems			Other		
Cold Feet			Mental Illness			Other		
Convulsions			Mitral valve prolapse					
Depression			Muscle pain					
Diabetes			Nausea					
Diarrhea			Nervousness					
Dizzy Spells			Numbness					
Excessive hunger			Osteoporosis					
Excessive thirst			Prostate Problems					
Excessive urination			Psoriasis					
Fainting spells			Rash					
Feet Swell			Rheumatic fever					
Fibromyalgia			Rheumatoid Arthritis					
Foot Ulceration			Sciatica					
Fractures			Seizure					
Gout			Sickle Cell Disease					
Heart attack			Skin Itching					

Family History: Check all the apply

	HEART DISEASE	DIABETES	HYPERTENSION	STROKE	MENTAL ILLNESS	CANCER	OTHER
MOTHER							
FATHER							
SIBLING							
CHILD							

Height:_____ **Weight:**_____

Last Blood Pressure Reading:_____ **Shoe Size**_____