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WELCOME TO ATLANTIC PODIATRY

Patient Information and Credit card Authorisation Form

Personal Details									
Full name of patient:									
Mailing Address:									
Physical address, if different:									
Phone number, Cell:	Home:		Work:						
Email Address:									
Date of birth: Day Month	Year	Sex: M F	Marital Status:	М	S	W	D		
Employer:									
Insurance Details									
Provider:	Group num	ber:							
Certificate:	Effective Date:								
Primary insured, if not patient:									
Relationship to primary insured:	Self	Spouse		Ch	ild				
Employer of primary insured:									
Address of primary insured:									
Phone number of primary insured:							. <u> </u>		
Emergency Contact									
Name:		Relationship to clie	nt:						
Phone number(s):		-							
General Practitioner Details									
Name of Practitioner:	ner: Clinic Name:								
Do you consent that we communicate with	ith your GP about your	condition if necessary	: Yes / No						
Are you under other physical care? Yes	/ No								
If yes, name and profession of practition	er:								



Reason for your visit

What is the main reason for your visit:								
When did this begin:								
How did this begin:								
Has this occurred before:	Yes / No	When:	_ Is it: Getting worse / Staying the same / Improving					
How did you become awar	e of our clinic: _							

Medical & Foot Health History

Please tick () next to any condition you presently have. Please cross (X) next to any condition you have previously had

Ankle Injury	Circulatory Problems	Heel Pain	Knee Pain	Rheumatoid Arthritis
Ankle Pain	Corns/Callous	High blood pressure	Liver Disease	Skin Conditions
Arch Pain	Cramps in legs	High Cholesterol	Neuropathy	Swelling in the feet
Arthritis	Diabetes	Hip Pain	Numbness in the feet	Tired/Aching Feet
Bleeding Disorder	Flat feet	H.I.V/ AIDS	Plantar Fasciitis	Leg/ Foot Ulcers
Blood Clot	Fungal Nail Infection	Itching/Rash on feet	Pregnancy	Varicose Veins
Bunions	Gout	Kidney Disease	Sciatica	Walking Problems
Cancer	Healing Issues	In-grown Toenail	Shin Splints	Warts

Other (Please Specify): _____

Do you have any allergies or have you had any reactions to adhesive tape, latex. Iodine, local aesthetic, or antibiotics?

Details:

Have you ever been to a Podiatrist? Yes / No

If yes, when/where was your last visit:

AUTHORISATION TO RELEASE INFORMATION AND PAY INSURANCE BENEFITS.

(Please Print)

I hereby authorize the practice to render podiatric medical services to me / my child / my elderly relative and to release any information regarding diagnosis and treatment of myself (my child or elderly relative) to my Insurance company regarding my claim. I also authorise payment directly to Atlantic Podiatry of benefits and I understand that I am responsible for any amount not covered by my insurance Company.

Signature of Patient/Guardian

Patient/Guardians' Name: _____ Date: _____

