ATLANTIC PODIATRY

Tel: 533-2508
Email: info@atlantic-podiatry.com
www.atlantic-podiatry.com

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: M S W D

Employer: _____

Insurance Details

Provider: Group number: _____

Certificate: _____ Effective Date: _____

Primary insured, if not patient: _____

Relationship to primary insured Self Spouse Child

Employer of primary insured: _____

Address of primary insured: _____

Phone number of primary insured: _____

Emergency Contact

Name: _____ Relationship to client: _____

Phone number(s): _____

General Practitioner Details

Name of Practitioner: _____ Clinic Name: _____

Do you consent that we communicate with your GP about your condition if necessary: Yes / No

Are you under other physical care? Yes / No

If yes, name and profession of practitioner: _____

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 aware 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 anesthetic, 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.

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: _____

(Please Print)

ATLANTIC PODIATRY