Colette S. Weber, DPM LLC
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WELCOME TO OUR OFFICE

PATIENT INFORMATION:

Last Name:_____First Name:_____ Middle Initial:____ Age: _____
Address:_____ City:_____State:_____ZIP:_____
e-Mail:_____ Home #:_____ Work #:_____Cell#:_____
How would you like to be contacted? e-Mail____Home#____Work#____Cell#____ Best Time:_____
Birth Date:_____ Sex:_____Social Security #:_____ Marital Status:_____
Employer:_____ How Long?: _____
Occupation:_____ Retired:_____ Student:_____
Whom may we thank for referring you?:_____
Family Physician:_____ Date Last Seen:_____

RESPONSIBLE PARTY INFORMATION: (FOR INSURANCE PURPOSES)

Last Name:_____First Name:_____ Middle Initial:____ Rel to Patient:_____
Address:_____ City:_____State:_____ZIP:_____
e-Mail:_____ Home #:_____ Work #:_____Cell#:_____
Birth Date:_____ Insured 's Social Security #:_____
Employer:_____ City & State:_____

INSURANCE INFORMATION:

Insurance Company:_____ Policy Holder:_____
Policy Number:_____ Group Number:_____
In Insurance through Employer?_____ Insured SS#:_____

SECONDARY INSURANCE

Insurance Company:_____ Phone # _____
Policy Number:_____ Group Number:_____
Is Insurance through Employer?_____ Insured SS#:_____

Emergency Contact Person:_____ Someone not at your address
Phone #_____ Relationship:_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Colette Weber all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Weber to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:_____
Relationship:_____ Date:_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Weber for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician 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, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature:_____ Date:_____

PODIATRIC HISTORY

My foot problems involve my:	_____ Left foot	_____ Right Foot	_____ Both Feet
It has troubled me for:	_____ Weeks	_____ Months	_____ Years
Level of Daily Physical Activity:	_____ Sedentary	_____ Active	_____ Very Active
How is your general health?	_____ Good	_____ Fair	_____ Poor
	_____ Height	_____ Weight	_____ Shoe size

Have you ever been seen by a Podiatrist?_____No_____Yes Dr._____ When?_____
Athletic activities and frequency?_____
What is the chief complaint for which you came to be treated?_____
What is your goal in treating this problem?_____

MEDICAL HISTORY

The following is important background information for Dr. Weber's treatment of your podiatric problem.

Major Illnesses or Injuries:Check all that apply. List any not mentioned here.

_____ Asthma	_____ Heart Trouble	_____ Stomach Ulcer
_____ Back Problems	_____ HIV/AIDS	_____ Stroke
_____ Blood Clots	_____ Hypertension	_____ Tumor or Growths
_____ Cancer	_____ Kidney Disease	_____ Ulcer of Leg
_____ Diabetes	_____ Liver Problems	_____ Varicose Veins
_____ Diffifulty Healing	_____ Pacemaker	_____ Artificial Heart Valve/Joints
_____ Gout	_____ Poor Circulation	

Other Illnesses:_____

Surgeries:_____

Medications you are currently taking:_____

_____

_____

_____

Pharmacy Name:_____ Phone # _____

FAMILY HISTORY

Has any member of your family had these diseases? Check all that apply.

_____ Cancer	_____ Heart Trouble	_____ Difficulty w/ Anesthesia
_____ Diabetes	_____ High Blood Pressure	

ALLERGIC REACTION OR ADVERSE EFFECTS FROM MEDICATIONS

Have you experienced an allergic reaction or adverse effect from the following, about which Dr. Weber should be aware?

_____ Aspirin	_____ Novocaine	_____ Sulfa
_____ Codeine	_____ Penicillin	_____ Tape/Adhesive
_____ Cortisone	_____ Seafood/Iodine	_____ Other (please list)_____

CURRENT MEDICAL PROBLEMS

Do you currently have any problems with the following areas? Circle all that apply.

General	Weight Loss, Weight Gain, Fever, Chills
Eyes	Poor Vision, Eye Pain, Tearing, Redness
Ears, Nose, Throat	Hearing Loss, Stuffy Nose, Earache, Cough, Dry Mouth
Cardiovascular	High Blood Pressure, Racing Pulse, Angina, Chest Pains
Respiratory	Congestion, Wheezing, Shortness Of Breath
Gastrointestinal	Upset Stomach, Diarrhea, Constipation, Hernia, Nausea, Vomiting
Genital, Kidney, Bladder	Painful Urination, Frequent Urination, Impotence, Jaundice
Females	Pregnant, Nursing, Taking Birth Control Pills
Muscles, Bones, Joints	Joint Pain, Stiffness, Swelling, Cramps, Arthritis
Skin	Pimples, Warts, Growths, Rash, Scaling
Neurologic	Numbness, Headache, Seizures, Paralysis
Psychiatric	Anxiety, Depression, Insomnia
Endocrine	Diabetes, Hypothyroidism, Pancreatitis
Blood/Lymph	Bleeding, Anemia, Blood Transfusions
Allergy/Immunology	Sneezing, Swelling, Redness, Itching, Hives, Lupus

SOCIAL HISTORY

Do you drink alcohol? _____No_____Yes If Yes, how much?_____How often?_____

Do you use tobacco products? _____No_____Yes If Yes, how many packs/day?_____How many years?_____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to Dr. Weber to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature:_____ Date:_____