WELCOME TO OUR OFFICE

Name _____

Date of Birth _____ Age _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email address _____

Sec: M F Marital Status S M D W

Primary Physician _____ Last Visit _____

Address _____

Employer _____ Occupation _____

Medical Insurance _____ Subscriber Name _____

SSN _____ File or Group No _____

Whom may we thank for referring you to this office?

Patient referral _____ (person's name)

Phone book _____ Insurance book _____ Dr. Referral _____ Web site _____

Doctor's name _____

I hereby authorize Rieter Podiatry to release information to the Insurance Company regarding myself or dependents for payment of claims via telephone, mail, fax, or electronically, concerning my illness and/or treatment. I understand and agree that I am ultimately responsible for payment. I certify this information is true and correct to the best of my knowledge. I understand that I am financially responsible for all fees and services rendered to me by Rieter Podiatry Associates whether or not fees are paid by my Insurance.

Date _____ Signature _____
(Parent or guardian if patient is a minor)

PATIENT HEALTH HISTORY

Name _____

Please describe your problem _____

_____

Do you have pain? Yes _____ No _____
If so, where is it located? _____
Describe its quality (stabbing, shooting, burning) _____
How severe is it? (mild, moderate, severe) _____
How long does it last? _____
Do shoes make it worse or better? _____

What medications are you taking? _____

_____

Which surgeries have you had in the last five years? _____

_____

Please check the correct responses below:

	Yes	No
Is there a family history of diabetes?	____	____
Is there a family history of heart disease?	____	____
Is there a family history of cancer?	____	____
Do you smoke?	____	____
Do you use alcohol?	____	____
Do you wear glasses or contacts?	____	____
To your knowledge, are you pregnant?	____	____
Any fever or unexplained weight loss in last year?	____	____
Any numbness or tingling in your feet or toes?	____	____
Any history of stomach ulcers or problems?	____	____
Any history of arthritis or joint pain?	____	____

Circle the allergies you have: None Adhesive tape Penicillin Local anesthetic (Novocain)

Other: (please list any other allergies: _____

Do you have any of the following:

____ Heart disease	____ AIDS or HIV	____ Circulatory disease
____ Diabetes	____ Kidney trouble	____ Cancer
____ Gout	____ High blood pressure	____ Mental health problems
____ Hepatitis	____ Liver trouble	____ Other

I hereby give my permission to Dr. Todd Rieter to perform a complete examination, to administer treatment and to perform such general procedures as may be deemed necessary in the diagnosis and/or treatment of the foot condition. I further certify that to the best of my belief and knowledge the information provided above personal health history is true and accurate.

Signature _____ Date _____