

Lafayette Podiatry Associates, P.C.

415 North 26th Street, Suite 305

Lafayette, IN 47904

(765) 449-4758

Patient's Name: _____ Date of Birth: _____ Age: _____ Sex: M F

Address: _____ City/State _____ Zip Code: _____

Home Phone Number: () _____ - _____ Social Security Number: _____

Employer Name: _____ Work Phone Number: () _____ - _____

Primary Care Physician: _____ Referring Physician: _____

Primary Insurance: _____ Secondary Insurance: _____

Spouse's Name: _____ Spouse's Social Security Number: _____

Spouse's Employer: _____ Spouse's Date of Birth: _____

(We will need this information on your spouse if he/she is the primary insurance carrier)

IF PATIENT IS A MINOR OR A STUDENT

(We must have authorization to treat if patient is under 18 and coming to our office alone!)

Mother's Name: _____ Mother's Work Phone Number: () _____ - _____

Mother's Social Security Number: _____ Mother's Date of Birth: _____

Mother's Address(if different): _____

Father's Name: _____ Father's Work Phone Number: () _____ - _____

Father's Social Security Number: _____ Father's Date of Birth: _____

Father's Address(if different): _____

1. I authorize the release of all information to my insurance companies, workers compensation carriers, and/or other treating physicians.
2. I authorize and request insurance payment directly to Lafayette Podiatry Associates, P.C.
3. I understand that I am responsible for my bill.
4. I authorize use of this form on all of my insurance submissions.
5. I authorize Lafayette Podiatry Associates, P.C. to act as my agent in helping obtain payment from my insurance companies and to help me obtain any required pre-certification.
6. I agree to pay for my bill in full plus court costs, attorney fees, and all collection fees if deemed necessary.
7. If insurance deems my procedure medically unnecessary, I will be responsible for payment.
8. I authorize treatment of my foot/ankle problems by Lafayette Podiatry Associates, P.C. and its associates.

Signature of Patient or Legal Guardian: _____ **Date:** _____

Medical History

Patient Name _____ Date _____

Primary Physician _____ Date you last saw him/her _____

Height _____ Weight _____ Shoe Size _____

What type of foot/ankle problem are you having? _____

What medications are you currently taking?(please list) _____

Are you allergic to any drugs or medications?(please list) _____

Please list any past surgeries _____

Do you smoke? _____ How much? _____ How Long? _____

Do you use alcohol? _____ Are you diabetic? _____

Do you exercise/play sports?(please list) _____

Check if you have/had a history of any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Low back pain/trauma |
| <input type="checkbox"/> Arthritis/Joint pain | <input type="checkbox"/> Heart problems/chest pain | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach/Intestinal problems/Hiatal Hernia/ Ulcer |
| <input type="checkbox"/> Brain/Nervous system problems | <input type="checkbox"/> Injury/Fracture | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breathing problems/ Lung Disease | <input type="checkbox"/> Kidney/Bladder problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> Total Joint Replacement |