Lafayette Podiatry Associates, P.C.

415 North 26th Street, Suite 305
Lafayette, Indiana 47904

Gregory A. Schweikher, DPM
Andrew C. Perry, DPM
Abigail M. Smith, DPM

Phone: (765) 449-4758
Fax: (765) 449-0659

Welcome to our office. Please complete this form to the best of your knowledge.

Patient Information:

Patient Name: _____ **Gender**: ❑M ❑ F
First Middle Last

SSN: _____ **DOB**: _____ **Email**: _____

***Is the patient a MINOR or have a POWER OF ATTORNEY? YES❑ NO❑ (If yes, please ask for corresponding paperwork.)**

Billing Information:

Mailing Address: _____
Street City State Zip Code

Home Phone: (_____) _____-_____ **Work Phone**: (_____) _____-_____

Cell Phone: (_____) _____-_____ **Upon contact, whom may we speak with**: Patient | Spouse | Parent

Employer: _____ **Employer Phone**: (_____) _____-_____

Emergency Contact: _____ **Emergency Phone**: (_____) _____-_____

Government Mandated Information: (ALL fields required) Primary Language: _____

Race: American Indian | Asian | Pacific Islander | African American | Caucasian **Ethnicity**: Hispanic/Latino | Non-Hispanic/Non-Latino

Marital Status: Single | Mar | Div | Wid **Student Status**: Part-time | Full-time | N/A **Employment Status**: Part-time | Full-time | N/A

Insurance Information: (ALL fields required if policy holder is not the patient, if policy holder is the patient simply circle self)

Primary Insurance Company: _____ **Policy Holder's Name**: _____

SSN: _____ **Birthdate**: _____ **Home Phone**: (_____)_____-_____

Policy holder's relationship to patient: Self | Father | Mother | Spouse | Other _____

Secondary Insurance Company: _____ **Policy Holder's Name**: _____

SSN: _____ **Birthdate**: _____ **Home Phone**: (_____)_____-_____

Policy holder's relationship to patient: Self | Father | Mother | Spouse | Other _____

Attention:

- I authorize the release of all information to my insurance companies, workers compensation carriers, and/or other treating physicians.
- I authorize and request insurance payment directly to Lafayette Podiatry Associates, P.C.
- I understand that I am responsible for my bill.
- I authorize use of this form on all of my insurance submissions.
- 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.
- I agree to pay for my bill in full plus court costs, attorney fees, and all collection fees if deemed necessary.
- If insurance deems my procedure medically unnecessary, I will be responsible for payment.
- I authorize the physicians of Lafayette Podiatry Associates, P.C. to treat my foot/ankle problems.

X

Patient/Guardian Signature **Date**

Lafayette Podiatry Associates, P.C.
415 North 26th Street, Suite 305
Lafayette, IN 47904
(765) 449-4758

Medical History

Patient Name: _____ **DOB:** _____ **Shoe size:** _____

Height: _____ **Weight:** _____ **Do you have Diabetes?** Y N **Recent A1C:** _____

Primary Physician: _____ **Referring Physician:** _____

Pharmacy & Location: _____

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

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

Do you smoke? Y N **Packs per day**: _____ **Number of Years**: _____
Do you use alcohol? Y N **If yes, please circle how often?** Rarely Often Socially

Have you received a flu vaccination for the current season? Y N
If you answered no, what was the reason? Allergy Declined Vaccine unavailable Other

If you are 65 years of age or older, please answer the following questions:
Have you ever received a pneumonia vaccine? Y N
Do you have a living will or someone arranged to make medical decisions on your behalf? Y N
If yes, please list the name of that person: _____

Medications:

Drug Name	Dose	Times Per Day	Drug Name	Dose	Times Per Day

Allergies:

Drug or Medication Name	Reaction or Side Effect

Patient Name: _____ DOB: _____

Surgical History:

Operations	Year	Operations	Year

Personal/Family Medical History:

(Please check any history of the following with either yourself or maternal (m) or paternal (p) family member)

Medical Condition	Self	Other	Medical Condition	Self	Other
Anemia		M_____ P _____	High Blood Pressure		M_____ P _____
Arthritis		M_____ P _____	High Cholesterol		M_____ P _____
Asthma		M_____ P _____	HIV/AIDS		M_____ P _____
Cancer (Skin)		M_____ P _____	Injury/Fracture		M_____ P _____
Cancer (Other) List:_____		M_____ P _____	Kidney Disease		M_____ P _____
Chronic Chest Pain		M_____ P _____	Liver Disease		M_____ P _____
Chronic Heartburn		M_____ P _____	Low Back Pain/Trauma		M_____ P _____
Colitis		M_____ P _____	Muscle Joint Pain		M_____ P _____
COPD		M_____ P _____	Nervous System Problems		M_____ P _____
Diabetes, Type 1 or Type 2		M_____ P _____	Osteoporosis		M_____ P _____
Epilepsy (seizures)		M_____ P _____	Rheumatoid Arthritis		M_____ P _____
Gastrointestinal Problems		M_____ P _____	Stroke		M_____ P _____
Gout		M_____ P _____	Thyroid Disorder		M_____ P _____
Heart Attacks		M_____ P _____	Total Joint Replacement		M_____ P _____
Hepatitis		M_____ P _____	Ulcers		M_____ P _____

Patient Signature: _____ Date: _____