PATIENT INFORMATION FORM

PLEASE PRINT & BE LEGIBLE
STAFF HAS TO BE ABLE TO READ

Robert Mullan, DPM, Inc.
PODIATRIST
Helping You Feel Better from Your Toes Up
ROBERT B. MULLAN, DPM, Inc.

DATE: ______________________

PATIENT NAME: ______________________ DATE OF BIRTH: ____________ AGE: ______

SEX: M F SOCIAL SECURITY#: ______________________

HOME ADDRESS: ______________________ CITY/STATE: ____________ ZIP: ______

____

MAILING ADDRESS: ______________________ CITY/STATE: ____________ ZIP: ______

____

MAY WE LEAVE MESSAGE?

HOME PHONE#: ______________ YES NO CELL PHONE#: ______________ YES NO

WORK PHONE#: ______________ YES NO E-MAIL: ______________ YES NO

PRIMARY LANGUAGE: ______________________

WHAT NAME WOULD YOU LIKE DOCTOR & STAFF TO CALL YOU BY? ______________________

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: ______________________

RELATIONSHIP: ______________ PHONE#: ______________

EMERGENCY CONTACT: ______________________ RELATIONSHIP: __________ PHONE#: __________

PRIMARY CARE DOCTOR: ______________________ WHO REFERRED YOU: ______________

PHARMACY: ______________ LOCATION: ______________ PHONE#: ______________

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

YES NAME(S): ______________________

NO ______________________

WHO IS RESPONSIBLE FOR PAYMENT? ______________ RELATIONSHIP TO PATIENT? ______________

ADDRESS: ______________________ CITY/STATE: ____________ ZIP: ______

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: ______________________ DATE OF BIRTH: ______________

POLICY HOLDER NAME: ______________________

ID #: ______________________ GROUP#: ______________________

SECONDARY INSURANCE NAME: ______________________ DATE OF BIRTH: ______________

POLICY HOLDER NAME: ______________________

ID #: ______________________ GROUP#: ______________________

PATIENT NAME: ______________________________

DATE OF BIRTH: ______________________________

YOUR MEDICAL HISTORY PLEASE CHECK & LIST ANY KNOWN ALLERGIES

ALLERGIES: ❏ NONE KNOWN ❏ TO MEDICATION(S) ______________________________

❏ ANESTHESIA ______________________________ ❏ FOODS ______________________________

❏ TAPE ❏ LATEX ❏ SHELLFISH ❏ IODINE ❏ OTHER ______________________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING?
(Please check appropriate box)

YES	NO		YES	NO		YES	NO	
❏	❏	ACID REFLUX	❏	❏	FIBROMYALGIA	❏	❏	NEUROPATHY
❏	❏	ANEMIA	❏	❏	GOUT	❏	❏	OPEN SORES
❏	❏	ARTHRITIS	❏	❏	HEART ATTACK	❏	❏	PNEUMONIA
❏	❏	ASTHMA	❏	❏	HEART DISEASE/FAILURE	❏	❏	POLIO
❏	❏	BACK TROUBLE	❏	❏	HEPATITIS	❏	❏	RHEUMATIC FEVER
❏	❏	BLADDER INFECTIONS	❏	❏	HIV+/AIDS	❏	❏	SICKLE CELL DISEASE
❏	❏	ABNORMAL BLEEDING	❏	❏	HIGH BLOOD PRESSURE	❏	❏	SKIN DISORDER
❏	❏	BLOOD CLOTS	❏	❏	KIDNEY DISEASE	❏	❏	SLEEP APNEA
❏	❏	BLOOD TRANSFUSION	❏	❏	LIVER DISEASE	❏	❏	STOMACH ULCERS
❏	❏	BRONCHITIS/EMPHYSEMA	❏	❏	LOW BLOOD PRESSURE	❏	❏	STROKE
❏	❏	CANCER	❏	❏	MIGRAINE HEADACHES	❏	❏	THYROID DISEASE
❏	❏	DIABETES	❏	❏	MITRAL VALVE PROLAPSE	❏	❏	TUBERCULOSIS

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? ______________________________

____

____

____

____

____

____

WHERE IS THE PAIN/PROBLEM LOCATED?

PLEASE MARK ON THE PICTURES BELOW.

PATIENT NAME: ______________________________

DATE OF BIRTH: ______________________________

NOTES:

____

____

____

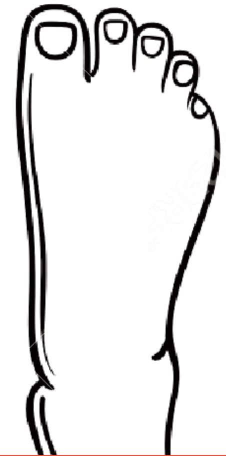
____

____

____

RIGHT FOOT

BOTTOM OF FOOT



TOP OF FOOT

OUTSIDE OF FOOT

OUTSIDE OF FOOT

LEFT FOOT

TOP OF FOOT

BOTTOM OF FOOT

INSIDE OF FOOT

OUTSIDE OF FOOT

NOTES:

____

____

____

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____

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PATIENT NAME: ______________________________

DATE OF BIRTH: ______________________________

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING *(INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):*

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ PARTNERED ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED

USE OF ALCOHOL: ❑ NEVER ❑ NO LONGER USE ❑ HISTORY OF ALCOHOL ABUSE

❑ **CURRENT USE -TYPE** ❑ RARE ❑ OCCASIONAL ❑ MODERATE ❑ DAILY

USE OF TOBACCO: ❑ NEVER ❑ QUIT- HOW LONG AGO?_____ ❑ SMOKE _____ PACKS/DAY FOR_____ YEARS

USE OF RECREATIONAL DRUGS: ❑ NEVER ❑ QUIT- HOW LONG AGO?_____TYPE ______________

❑ CURRENT USE -TYPE ______________________ ❑ RARE ❑ OCCASIONAL ❑ MODERATE ❑ DAILY

EMPLOYER:______________________________ **OCCUPATION:** ______________

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ❑ 10% ❑ 25% ❑ 50% ❑ 75% ❑ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ❑ CHILDREN-AGE(S) _____ ❑ PET(S)-WHAT KIND? _____

❑ ELDERLY OR DISABLED FAMILY MEMBER ❑ OTHER ______________________________

EXERCISE: ❑ NEVER ❑ RARE ❑ OCCASIONAL ❑ WEEKLY ❑ SEVERAL TIMES A WEEK ❑ DAILY

TYPES OF EXERCISE:

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ❑ DIABETES ❑ CANCER ❑ HEART DISEASE ❑ HIGH BLOOD PRESSURE

❑ STROKE ❑ CORONARY ARTERY DISEASE ❑ THYROID DISEASE ❑ RHEUMATOID ARTHRITIS

❑ OTHER______________________________

PATIENT NAME: ____

DATE OF BIRTH: ____

HOW LONG AGO DID THIS PROBLEM FIRST START? ________ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ❑ BEGIN ALL OF A SUDDEN ❑ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ❑ NO PAIN ❑ SHARP ❑ DULL ❑ ACHING ❑ BURNING

❑ RADIATING ❑ ITCHING ❑ STABBING ❑ OTHER ________________________________

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? *(PLEASE CIRCLE)*

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 **(WORST PAIN POSSIBLE)**

SINCE THE TIME YOUR PAIN/PROBLEM BEGAN, HAS IT:
❑ STAYED THE SAME ❑ BECOME WORSE ❑ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE?
❑ WALKING ❑ STANDING ❑ DAILY ACTIVITIES ❑ RESTING ❑ DRESS SHOES ❑ HIGH HEELS
❑ FLAT SHOES ❑ ANY CLOSED TOE SHOE ❑ RUNNING ❑ OTHER________________________

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER?________________________________

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? ____________________________

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? ________________

WAS THIS PROBLEM CAUSED BY AN INJURY? ❑ YES ❑ No (DESCRIBE) ________________

____

IF YES,WAS IT A WORK-RELATED INJURY? ❑ YES ❑ No

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

________________________________ ________________________________
PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

________________________________ ________________________________
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

____
SIGNATURE

____
DATE

OFFICE POLICIES/LIABILITY WAIVER

ACKNOWLEDGMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understand the Notice.

APPOINTMENT NOTIFICATION

The office understands that sometime you, the patient, might have an emergency arise and you forget to cancel the appointment. Our office will charge you $25.00 for not cancelling or any missed appointments and the insurances will not pay for this service.

If you are 15 minutes or more late to an appointment and you will be rescheduled unless prior notification is given.

PATIENT LIABILITY WAIVER

It is important that you, the patient, submit a copy of your ID and insurance coverage. If there is a change of insurance coverage, it is your responsibility to notify the office of the change and provide a copy of the new insurance coverage, before services are rendered. If the insurance denies a claim due to termination of coverage, this will be come your responsibility to pay for the account balance or services. Although, we make every effort to obtain accurate information of your insurance carrier, verification of benefits is not a guarantee that an insurance carrier will pay a claim. The insurance carrier makes the final determination based upon the plan's level of coverage and associated policies, upon receiving the claim.

Deductibles and copayments are due to Robert B. Mullan, DPM, Inc. at the time of service. Patient agrees to pay all deductibles, coinsurance, and services deemed "patient responsibility" as identified by the insurance carrier.

YOU, the patient, are responsible for obtaining any necessary referral from the Primary Care Physician before the appointment time. If you do not have a referral or Primary Care Physician has not faxed a referral, you will have to be rescheduled until referral is obtained. Claims denied due to lack of a referral will become your responsibility.

In the event that a patient does not have insurance coverage and is paying for the service in full at the completion of the consultation, we may offer a discount off of our billable amount.

The office accepts Visa, MasterCard, Checks, or Cash. There is a $30.00 fee for any returned checks, plus the amount of the check.

I have read the about information and agree to the terms contained therein.

Print Patients Name

Patient/Guardian Signature

Date

ROBERT B. MULLAN, DPM, Inc.