GULSO PODIATRY, L.L.C.

PATIENT INFORMATION

Date_____

SS#_____

Patient Name _____
Last First MI

Address_____

City_____

State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birth Date_____

☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Minor

Patient Employer/ School_____

Employer/School Address_____

_____

Employer/School Phone (_____)_____

Spouse's Name _____

Birth Date_____

Spouse's Employer_____

Who may we thank for referring you?_____

Contact Information

Home/Cell phone (_____) _____

Email _____

Work Phone (_____)_____

Best time and number to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____

Relationship_____

Home Phone (_____)_____

Work/cell Phone (_____) _____

INSURANCE

Responsible party?_____

Relationship to Patient_____

Insurance Co._____

Group #_____ ID#_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_____

Birth Date_____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____ ID#_____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. Gulso 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 authorized the use of my signature on all insurance submissions and hereby authorize release of information for insurance claim processing. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court cost. All past due accounts will be charged a $3.00 per month fee.

The above named doctor may use my Healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Dr. Gulso for any services furnished to me by that provider.
To the extent permitted by law, I authorized any holder of medical or other information about me to release to the Center for Medicare and Medicaid services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits payable for related services.

_____
Signature

_____
Please print name

_____ _____
Date Relationship to patient

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include any foot, ankle, knee, thigh, and hip complaints.)

_____

_____

_____

Have you ever been to a podiatrist before?
☐ Yes ☐ No
If yes, please list

Name_____

Date of Last Visit_____

Is there any personal or family history of diabetes?

☐ Yes ☐ No

Your occupation_____

Cigarette/Tobacco use_____

If yes, years smoked_____

Athletic activities in which you participate
(Please list activity and frequency)

_____

_____

Please indicate which foot problems you now have or have had in the past

Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Calluses	☐ Yes	☐ No
Numbness in Feet or Legs	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Heel Pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Neuromas	☐ Yes	☐ No
Plantar Warts	☐ Yes	☐ No
Swelling in Ankles or Feet	☐ Yes	☐ No
Tired Feet	☐ Yes	☐ No

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Allergies to Anesthetics	☐ Yes	☐ No	Eye Problems	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Allergies to Medicine or Drugs	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Foot or Leg Cramps	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Artificial Heart Valves or Joints	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Swelling in Ankles, Feet	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis or Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tired Feet	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Chronic Diarrhea	☐ Yes	☐ No	Neuropathy	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Ear Problems	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Surgeries you have had_____

_____

_____

Hospitalization other than for the surgeries listed_____

_____

_____

Family physician_____ Date of last visit _____

Are you, or have you been, under any doctor's care for any reason in the past two years? ☐ Yes ☐ No

If yes, please explain_____

_____

_____

MEDICATION

Include prescriptions, over-the-counter medications and vitamins_____

_____

_____

_____

_____

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

☐ Adhesive/Tape
☐ Anticoagulant Therapy
☐ Aspirin
☐ Codeine
☐ Demerol
☐ Iodine
☐ Local Anesthetic
☐ Novocaine
☐ Penicillin
☐ Sea food
☐ Sulfa

Other

_____

TREATMENT CONSENT

I hereby consent and give my permission to the physician (and his/her assistant or designated replacement) to administer and perform such procedures upon me as deemed necessary.

_____ _____

Signature of patient (Guardian if patient is a minor) Date

_____ _____

Please print name Relationship to the patient