S.F. HARTLEY, DPM, PC

The Foot Specialist

DR. MOHAMMED FAROOQUI DR. DAREN GUERTIN

TODAY'S DATE: _____

PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

HOME ADDRESS: **(STREET ADDRESS, CITY, STATE, ZIP)**
Street Address_____
City, ST, Zip_____

MAILING ADDRESS ***(if different from above)***
Street Address: _____
City, Zip: _____

SEX: MALE____ FEMALE____

SS#: _____

HOME PHONE #:_____

CELL/ ALT #: _____

EMAIL:_____

MARITAL STATUS:

MARRIED___ SINGLE___ DIVORCED___ WIDOW___

EMPLOYER INFORMATION

EMPLOYER NAME:_____ WORK NUMBER:_____

EMPLOYER ADDRESS:_____
_____

MAY WE CONTACT YOU AT WORK? YES NO

SPOUSE INFORMATION (IF APPLICABLE)

SPOUSE NAME: _____ DATE OF BIRTH: _____

EMPLOYER NAME: _____ WORK NUMBER:_____

PERSON RESPONSIBLE FOR ACCOUNT (IF DIFFERENT FROM PATIENT)

NAME: _____ HOME PHONE #:_____

MAILING ADDRESS: (if different from HOME address)
Street Address:_____
City, Zip: _____

CELL/ALT #: _____

DL#: _____

RELATIONSHIP TO PATIENT: _____

EMERGENCY CONTACT INFORMATION: IF AN EMERGENCY WHOM DO WE CONTACT FOR YOU?

NAME:_____ RELATIONSHIP TO PATIENT: _____

HOME PHONE #: _____ CELL/ALT #: _____

RACE/ETHNICITY/LANGUAGE

Race: Please circle one: American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; White; Other; or Decline to answer

Ethnicity: Please circle one: Hispanic or Latino; Not Hispanic or Latino; Unknown; or Decline to answer

Preferred language spoken at home: _____

PLEASE TELL US HOW YOU WERE REFERRED TO OUR OFFICE: (*CIRCLE ONE*)

DOCTOR INSURANCE INTERNET PHONE BOOK SCHOOL PERSONNEL

PATIENT SIGN HOSPITAL FAMILY/FRIEND OTHER:_____

Patient Name: _____ Date of Birth_____

Type of foot problem_____

_____

Length of time with problem_____

Prior or self treatment_____

MEDICAL HISTORY Circle any condition YOU currently have or have had:			
Anemia	Ear/hearing problem	HIV(AIDS)	Phlebitis
Asthma	Epilepsy	Kidney/Urine problems	Poor vision/Eye problems
Arthritis	Fever	Leg cramps	Sickle Cell Anemia
Allergies (seasonal)	Gout	Liver problems	Stomach Ulcers/Problems
Artificial Joints	Heart problems	Low Back problems	Stroke
Bleeder	Heart Valve Implant	Mental/Emotional problems	Thyroid
Chest pains	Hepatitis	Muscle Pain	Tuberculosis
Cancer	High Blood Pressure	Neurological/Muscular problems	Unequal Leg Length
Diabetes YES NO	High/Low Cholesterol	Nerve Pain	Varicose Veins
Insulin? YES NO			

If **DIABETIC**, doctor treating diabetes:

Dr. Name_____ Phone #_____ Last date seen_____

MEDICATIONS List any prescriptions and dosage, over-the-counter, and vitamins If none, please write "NONE"		

PHARMACY NAME, PHONE NUMBER, AND LOCATION:

ALLERGIES List any allergies (EX: penicillin, tape, etc) If none, please write "NONE"		

ADDITIONAL HISTORY	
Do you smoke: YES NO If yes, amount_____	List any surgeries/hospitalizations in last 5 years
Do you drink alcohol: YES NO If yes, amount_____	
What is your **Height**_____ **Weight**_____ Shoe Size_____	
Name of Family Doctor:	
Dr phone number:	

Circle YES or NO to report your **FAMILY HISTORY** (blood relatives)

	RELATIVE		RELATIVE
Diabetes YES NO		Flat Feet YES NO	
Cancer YES NO		Tuberculosis YES NO	
Bleeder YES NO		High Blood Pressure YES NO	
Hepatitis YES NO		HIV (AIDS) YES NO	
Bunions YES NO		Heart Problem/Stroke YES NO	
Hammertoe YES NO		Circulation Problem Leg/Feet YES NO	

INSURANCE INFORMATION

(IF WE MADE A COPY OF YOUR INS CARDS, PLEASE READ AND SIGN THIS FORM ONLY)

PRIMARY INSURANCE NAME:	SUBSCRIBER NUMBER:	GROUP NUMBER:
NAME OF POLICY HOLDER:	DATE OF BIRTH:	RELATIONSHIP TO PATIENT:
ADDRESS OF POLICY HOLDER (IF DIFFERENT FROM PATIENT)		
SECONDARY INSURANCE NAME:	SUBSCRIBER NUMBER:	GROUP NUMBER:
NAME OF POLICY HOLDER:	DATE OF BIRTH:	RELATIONSHIP TO PATIENT:
ADDRESS OF POLICY HOLDER (IF DIFFERENT FROM PATIENT):		

You certify that you (or your dependent) have insurance coverage with _____ and assign directly to S. F. Hartley, DPM, PC all insurance benefits, if any, for services rendered. You authorize the use of this signature on all insurance submissions and certify that the information provided here is true and correct.

S. F. Hartley, DPM, PC may use your health care information and may disclose such information to the above named insurance company(ies) and their agents for obtaining payment for services and determining insurance benefits or the benefits payable for related services. You authorize Social Security Administration to disclose information regarding your Medicare coverage (if applicable), including but not limited to: verification of your Medicare number, effective dates, and type of coverage.

Insurance benefits are verified by us as a courtesy to you. You may want to verify your own insurance as well. This would need to be done before treatment is rendered. The benefits that are given to us over the telephone, fax, or internet are not a guarantee of payment. If the insurance company gives us incorrect information and/or they process or pay charges differently from what was told to us, you are still responsible for all the charges that are incurred.

You certify that you have read the foregoing and are the patient or are duly authorized by the patient as patient's general agent to execute the above and accept its terms. It is further understood that this release remains in effect unless otherwise revoked.

_____ _____

Signature of Patient/Guardian/ Personal Rep Date

_____ _____

Print Name of above signature Relationship to Patient if not self