This form can be completed on the screen and printed. Use TAB key to jump to the next field. Fields in red are required. Once you have completed it, print it out and sign to bring to your appointment.

# Dahlonega Foot & Ankle Clinic - Bruce A Pichler, DPM

## Patient Information

Last Name:________________________________ First Name:_______________________ Middle:________________

Gender: female male Date of Birth:____________________ SSN:__________________

Address:__________________________________________ City:_______________ State:______ Zip:___________

Home Phone: _________________ Work Phone: _________________ Cell Phone: _________________

E-mail address:____________________________________________________________________________________

Contact Preference: Home Phone "Work Phone "Cell Phone Email Marital Status:________________

Emergency Contact:________________________________Relationship_____________ Telephone:________________

How did you hear about our practice?:___________________________________________________________________

Employer Name:________________________________________________Occupation:__________________________

**Insurance Information - Please provide copy of all insurance cards**

Primary Insurance Plan Name:_____________________________ Policy Holder:______________________________

Secondary Insurance Plan Name:____________________________ Policy Holder:______________________________

**Guarantor Information - For consenting adults over 18, Guarantor is "Self"**

Last Name:________________________________ First Name:_______________________ Middle:________________

Home Phone: _________________ Work Phone: _________________ Cell Phone: _________________

Address:______________________________________________ City:_______________ State:______ Zip:_________

**Notice of Privacy Practices:** This office will only use your medical information to aid in billing and provide better medical care.

**Signature on File:** My signature below allows this office to bill my insurance company for services provided to me.

**Insurance Assignment & Release**: I certify that I have the above listed insurance and assign directly to this office all insurance benefits, if any, otherwise payable to me for medical services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The office may use my health information and may disclose such information to the above named insurance company(ies).

**Treatment Authorization:** The undersigned herby consents to receive medical and healthcare services by Dahlonega Foot & Ankle Clinic Physicians and assistants as my provider deems necessary. Such services include examination, diagnostics, and treatments. A photocopy of this authorization and assignment shall be considered as valid as the original.

Signature of Patient / Guardian:_________________________________________________________________

**Patient Medical History**

Patient Name:_______________________________________________Age:_________Date:___________________

Occupation:______________________________ Favorite Exercise & Frequency:______________________________

Height:___________ Weight:__________ Tobacco/alcohol use both past & present:_____________________________

Pharmacy name & location:_____________________________________________________________________

What is the primary concern that brings you to the office today:_______________________________________________

Family Physician:___________________________________________ Date Last Seen:__________________________

**Foot History:** Have you ever been to a Podiatrist before: yes no

If "yes" please list name:__________________________________________________ Last visit:___________________

What condition:_____________________________________________________________________________________

Please indicate which foot problems you now have or have had in the past and describe if applicable:

| | Y | N | |
|---|---|---|---|
| Ankle pain | | | ______________________________________ |
| Athlete's foot | | | ______________________________________ |
| Bunions | | _ | ______________________________________ |
| Corns/callouses | | | ______________________________________ |
| Cramps/burning | | | ______________________________________ |
| Flat feet | | | ______________________________________ |
| Fractures | | | ______________________________________ |
| Gout | | | ______________________________________ |
| Hammertoe | | | ______________________________________ |
| Heel pain | | | ______________________________________ |
| Ingrown nail | | | ______________________________________ |
| Numbness | | | ______________________________________ |
| Plantar wart | | | ______________________________________ |
| Swelling | | | ______________________________________ |
| Tired feet | | | ______________________________________ |
| Other | | | ______________________________________ |

Patient Name:______________________________________________________ (medical history page 2)

List current medications or attach list. Please include over the counter and prescription medications.

______________________________________________________________________

Allergies to medications?

______________________________________________________________________

Past surgeries – dates and purposes:

______________________________________________________________________

Hospitalization dates and purposes

______________________________________________________________________

| | Y | N | Details if any |
|---|---|---|---|
| AIDS/HIV | | | |
| Allergies to anesthetics | | | Reaction:____________________ |
| Allergies to medications | | | Reaction:____________________ |
| Anemia | | | ____________________ |
| Angina | | | ____________________ |
| Arthritis | | | Type & location____________________ |
| Artificial heart valve | | | ____________________ |
| Artificial joint | | | Where:____________________ |
| Asthma | | | ____________________ |
| Back problems | | | ____________________ |
| Bleeding disorder | | | ____________________ |
| Broken bones | | | Date and description:____________________ |
| Cancer | | | Type & status:____________________ |
| Chemical dependency | | | ____________________ |
| Chest pain | | | ____________________ |
| Circulation problems | | | ____________________ |
| Cramps of foot or leg | | | ____________________ |
| Diabetes | | | ____________________ |
| Emphysema | | | ____________________ |
| Eye problems | | _ | ____________________ |
| Gout | | | ____________________ |
| Headaches | | | ____________________ |
| Heart disease | | | ____________________ |
| Hepatitis | | | ____________________ |
| High blood pressure | | | ____________________ |
| Kidney disease | | | ____________________ |
| Liver disease | | | ____________________ |
| Low blood pressure | | | ____________________ |
| Neuropathy | | | ____________________ |
| Phlebitis | | | ____________________ |
| Psychiatric care | | | ____________________ |
| Radiation treatment | | | ____________________ |
| Rash | | | ____________________ |
| Respiratory disease | | | ____________________ |
| Stroke | | | ____________________ |
| Swelling in feet/ankles/legs | | | ____________________ |
| Thyroid | | | ____________________ |