

TUSCANY PODIATRY, P.C.
PATIENT INFORMATION SHEET
(PLEASE PRINT)

PATIENT NAME _____
LAST FIRST M.I.

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE (____) _____ - _____ CELL PHONE (____) _____ - _____

DATE OF BIRTH ____ / ____ / ____ AGE ____ SSN: _____ - _____ - _____

CIRCLE ONE: MALE FEMALE MARITAL STATUS: _____

E-MAIL ADDRESS: _____

EMPLOYMENT INFORMATION

EMPLOYER NAME _____

WORK PHONE (____) _____ - _____ MAY WE CONTACT YOU AT WORK? _____

RESPONSIBLE PARTY INFORMATION
(REQUIRED IF PATIENT IS UNDER 18 YEARS OF AGE)

RESPONSIBLE PARTY NAME _____
LAST FIRST M.I.

RELATIONSHIP TO PATIENT _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE (____) _____ - _____ CELL PHONE (____) _____ - _____

INSURANCE INFORMATION
(REQUIRED IF PATIENT IS NOT THE POLICYHOLDER)

PRIMARY INSURANCE CARRIER _____

SECONDARY INSURANCE CARRIER _____

CONTRACT HOLDER NAME _____
LAST FIRST M.I.

RELATIONSHIP TO PATIENT _____ DATE OF BIRTH ____ / ____ / ____

PLEASE CHECK THE APPROPRIATE PLACES IF YOU NOW HAVE OR HAVE HAD IN THE PAST ANY OF THE FOLLOWING:

DIABETES ASTHMA ANEMIA CANCER TUMORS

GOUT STROKE NERVOUSNESS EPILEPSY GLAUCOMA

LIVER DISEASE HEART TROUBLE KIDNEY TROUBLE

STOMACH ULCERS HIGH BLOOD PRESSURE RHEUMATISM OR ARTHRITIS

BLEEDING DISORDERS HIV AIDS OTHER _____

HEIGHT _____ WEIGHT _____ SHOE SIZE _____

I AM NOT ALLERGIC TO ANYTHING THAT I AM AWARE OF

I AM ALLERGIC TO (CHECK ALL THAT APPLY)

ANTIBIOTICS ASPIRIN DEMEROL NOVOCAIN IODINE

TAPE MERCURIALS (MERCUROCHROME, MERTHIOLATE) CODEINE

PENICILLIN OTHER _____

HAVE YOU HAD ANY PREVIOUS SURGERY? _____ IF YES PLEASE LIST _____

WHAT PHARMACY DO YOU USE? _____

PRIMARY PHYSICIAN'S NAME _____

DATE YOU LAST SAW THIS DOCTOR? _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? _____

WHAT TYPE OF FOOT PROBLEMS BRINGS TO YOU OUR OFFICE? _____

DO YOU PLAY ANY TYPES OF SPORTS? _____ IF SO WHAT SPORTS? _____

BY WHOM OR WHAT ADVERTISEMENT WAS YOU REFERRED? _____

CONSENT FOR TREATMENT/FINANCIAL AGREEMENT

I STATE THE PRECEDING INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE AND I HEREBY GIVE MY PERMISSION TO PATRICIA M. ANTERO, PDM AND HER STAFF TO ADMINISTER TREATMENT AND PERFORM SUCH MINOR OPERATIVE PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY OR MINOR CHILD'S FOOT CONDITION. I WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED BY ME OR MY MINOR CHILD. I UNDERSTAND THAT MY INSURANCE WILL BE FILED AS A COURTESY TO ME BUT THAT I AM ULTIMATELY RESPONSIBLE FOR ALL INCURRED EXPENSES. SHOULD COLLECTION PROCEEDINGS BECOME NECESSARY, I AGREE TO PAY FOR ALL COSTS OF COLLECTION INCLUDING INTEREST AND A REASONABLE ATTORNEYS FEE AND WAIVE ALL RIGHTS TO CLAIM PROPERTY EXEMPT UNDER THE LAWS OF THE STATE OF ALABAMA.

SIGNATURE _____ DATE _____

PRINTED NAME _____