Family Foot Center

Sharon L. Pletcher, D.P.M.
1318 West College Avenue
State College, PA 16801
Phone: 814.235.5565
Fax: 814.235.1922

Date:_______________

1. Have you been seen by Dr. Pletcher before? Yes( ) No( )
   If yes, where (office/hospital/other facility)?
   Approximate date of last exam: _________________________

2. Patient information:
   Name: ____
   (Last name, First name, Initial)
   Address: ____
   City: ______________________ State: _______________ Zip: _______
   Home Phone: __________________ Work Phone: _____________________
   Employer: ____
   Social Security Number:______________________________Sex: M F
   Marital Status: S M D W O Date of Birth: _______________ Age: ______
   Are you a student? NA ( ) Yes: Full-time ( ) Part-time ( )

3. Person to Contact in Case of Emergency
   Name: _____________________________________ Phone: _________________
   Relationship to Patient: ____

4. Who may we thank for referring you to the practice?
   Source: ____
   Address: ____

5. Insurance Information:
   Do you have medical insurance? Yes ( ) No ( )
   Primary Coverage: ____
   (If this is Medical Assistance, please tell receptionist)
   Is this a group or individual policy? _______________________________________
   Agreement or ID #: ____
   Person whose name the policy is listed under: _______________________________
   Employer: ____
   Employer Address: ____

6. Complete this section if patient is not the subscriber OR if person responsible for payment is not the patient.
   Subscriber name: ____
   Address (if different than patient): ____
   City: ______________________ State: ____________ Zip: __________________
   Phone: _____________________ Date of Birth: _______________________________
   Subscriber sex: M F Relationship to patient: _____________________
   Employer: ____
   Address: ____
   City: ______________________ State: ____________ Zip: __________________

Patient information (cont.):

7. Is your visit related to an accident? Yes ( ) No ( )

8. Please note your secondary coverage (if you have any)
   Subscriber name: ______________________________
   Secondary insurance carrier: ______________________________
   Agreement or ID #: ______________________________
   Is Medical Assistance your secondary carrier? Yes ( ) No ( )

THE FOLLOWING IS REQUIRED BY LAW:
PLEASE READ CAREFULLY AND SIGN

I authorize *Family Foot Center* to release any information to the Health Care Financing Administration, PA Medical Assistance and/or my insurance company required to process my health care claim for services rendered by *Family Foot Center*. I understand that my signature authorized Sharon L. Pletcher, D.P.M., to examine and treat me. I also understand that payment for services or items may be from Federal and/or State Laws.

I hereby request that payment be made directly to *Family Foot Center* by any authorizing Medicare, PA Medical Assistance, and/or any other insurance company for any and all services rendered to me through *Family Foot Center.*

I understand that I am personally responsible for all charges which Medicare, PA Medical Assistance, and/or any other insurance company may not pay, including, but not limited to, co-insurance, deductibles, and non-covered services. I agree to make payment in full for services within thirty (30) days of receipt of billing. Finally, I understand and agree that this authorization will remain in effect until such time that I request, in writing, termination of this authorization.

Patient Name (please print): ______________________________
Signature: ______________________________ Date: ______________
Witness: ______________________________ Date: ______________

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Medical History *It is very important that you complete this form in its entirety.*

In your own words, please describe the problem you are having with your foot or ankle:
____

PAST TREATMENT: Have you sought any treatment for this condition to date?
____

PAST MEDICAL HISTORY: please check if applicable

Yourself	Family member	
________	______________	Heart disease
________	______________	Heart attack
________	______________	High blood pressure
________	______________	Stroke
________	______________	Thyroid disease
________	______________	Diabetes
________	______________	Cancer (type ___________)
________	______________	Cataract
________	______________	Glaucoma
________	______________	Macular degeneration
________	______________	Stomach ulcers
________	______________	Back pain (disc, sciatica)
________	______________	Arthritis
________	______________	Gout
________	______________	Hepatitis or liver disease
________	______________	Blood clots or phlebitis
________	______________	Bleeding problems
________	______________	Vascular problems
________	______________	Pneumonia
________	______________	Emphysema, asthma, bronchitis
________	______________	Seizures
________	______________	Polio
________	______________	Kidney disease or renal disease
________	______________	Prostate or urinary problems
________	______________	Menstrual or gynecological problems
________	______________	Venereal disease
________	______________	HIV or ARC or AIDS
________	______________	Parkinson's disease
________	______________	Neuropathy or paralysis

PAST SURGICAL HISTORY: List any operations (such as hernia, gall bladder, appendix, wisdom teeth, tonsils, C-sections, foot surgery, etc.) you have undergone, and the date of the surgery.
____
____
____

Height ____________ **Weight** ____________ **Shoe Size** _______________

MEDICATIONS: List any medications you are taking, and the dosages; include vitamins/supplements:
Please list on MEDICATIONS sheet

ALLERGIES: List any allergies (skin rash, trouble breathing) or adverse reaction (nausea, light-headedness, etc.) to medications or other substances (such as antibiotics, anesthetics, antiinflammatories, iodine or shellfish, adhesive tape).
____
____

SOCIAL HISTORY:

Occupation, and how many hours per day spent on your feet: ____________________________

Do you currently smoke, or have you ever, smoked cigarettes? Yes ( ) No ( )
If so, how many packs per day? _________ packs/day
If so, how many years have you smoked? _________ years of smoking
If you quit smoking, what year did you quit? __________

Do you drink alcoholic beverages regularly? Yes ( ) No ( )

Do you live alone? Yes ( ) No ( )

REVIEW OF SYSTEMS: Do you frequently or currently have any of the following conditions?

Blurred vision _____
Dizzy/fainting spells _____
Headaches _____
Trouble swallowing _____
Dry mouth/eyes _____
Lumps in neck _____
Shortness of breath______
Chest pain _____
Cough ______
Nausea _______
Vomiting ______
Diarrhea _____
Constipation ______
Trouble urinating _______
Bleeding _____
Joint pain ______
Low back pain _______
Weakness _____
Difficulty walking ______
Numbness/tingling/burning of hands or feet _____
Pain in legs when walking _____
Skin rash _____
Cold sensitivity in hands or feet _____
Fever/chills _____
Other ____

Who is your family doctor (name and address, please)?
____

Thank you for providing the above information. Area Below for Office Use Only.

_____________________________________ ______________________
Reviewing Physician Date