Brandywine Podiatry
Center of Excellence
www.brandywinepodiatry.com

Patient Health History

Name (Last, First, MI): **Date of Birth:** / /

Address: ______________________________ Age: ____________

City: ________________ State: ______ Zip: ________ Sex: Male / Female

Phone #: (Home): ______________ (Cell): ______________ (Work): ____________________

Personal Email: ______________________________ Social Security #: __________________

Race: ________________ Ethnicity: Hispanic/Latino Non-Hispanic/Latino Other

Primary Care Physician and #: ____

Endocrinologist or Cardiologist and #____

Employer: ___________________________ Occupation: _____________________________

Insurance subscriber's name and DOB:____

Emergency Contact: ___________________________ Emergency Contact #: ______________

How did you hear about Brandywine Podiatry?: ______________________________________

Reason for visit: ____

Date of Injury or when problem occurred? ____

Allergies:
- No Known Allergies
- YES If so, please list all Drug, Food, and Environmental Allergies.

____

- No Current Medications

Medications (include over the counter medications)**:**
Please list all current medications that you are taking and their corresponding dosages below (if known):

Medication	Dosage	Medication	Dosage

Preferred Pharmacy:
Name of Pharmacy:____
Pharmacy Location (*Street, City, State*): _________________________________
Pharmacy Phone Number (if known):_______________________________________

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Personal Medical History: • No Known Problems; OR please check all that apply

• Anemia	• Diabetes	• High Cholesterol	• Mental Illness	• Blood Clots
• Anxiety/Depression	• Diverticulitis	• HIV/ AIDS	• Stroke	• Gout
• Arthritis	• Fibromyalgia	• Hypertension	• Thyroid Disease	• Joint Replacements
• Asthma	• Heart Disease	• Kidney Disease	• Psoriasis	• GI Problems
• Circulation Problems	• Hepatitis/ Liver Disease	• Neurological Disorders	• Cancer	• Other

Procedures & Surgeries: • None • YES. If so, please list all Procedures/Surgeries with dates below.

____

____

Family History: (check all that apply)

• Negative • Unknown • Unable to Obtain • Adopted

Type	*Mother*	*Father*	*Sister*	*Brother*	*Grandmother Maternal*	*Grandmother Paternal*	*Grandfather Maternal*	*Grandfather Paternal*
Anesthesia Problems	•	•	•	•	•	•	•	•
Arthritis	•	•	•	•	•	•	•	•
Bleeding Problems	•	•	•	•	•	•	•	•
Blood Clots/Circulation Problems	•	•	•	•	•	•	•	•
Depression/ Anxiety	•	•	•	•	•	•	•	•
Diabetes	•	•	•	•	•	•	•	•
Cancer	•	•	•	•	•	•	•	•
Foot Problems	•	•	•	•	•	•	•	•
Heart Attack/ Heart Disease	•	•	•	•	•	•	•	•
High Blood Pressure	•	•	•	•	•	•	•	•
High Cholesterol	•	•	•	•	•	•	•	•
Mental Illness	•	•	•	•	•	•	•	•
Stroke	•	•	•	•	•	•	•	•
Other	•	•	•	•	•	•	•	•

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Social History:

Alcohol Use:	• Current	• Past	• Never
Please check if applicable:	• Beer	• Wine	• Liquor
Tobacco Use:	• Current	• Past	• Never
Please check if applicable:	• Cigarettes	• Cigar	• Oral
	• Pipe	• Snuff	• Other
Drug Use:	• Current	• Past	• Never
Please list if any:			
Exercise & Physical Activity:	• Never	• 1-2 times/wk	• 3-4 times/wk
	• 5-6 times/wk	• Daily	• Other:

Are you Pregnant? ___________________________________ Breastfeeding? _______________________________________

Shoe Size:_______________________________

Are you *currently* experiencing any of the following:	**Yes**	**No**	**If yes, please explain**
General (Chronic fever, unexpected weight loss/gain, fatigue)	€	€	_____________________
Eye (Double vision, glaucoma, vision loss, cataracts)	€	€	_____________________
Ear/Nose/Throat (Hearing loss, sinus problems, dizziness)	€	€	_____________________
Heart (Chest pains, irregular heartbeats, heart murmur)	€	€	_____________________
Respiratory (Shortness of breath, wheezing, coughing)	€	€	_____________________
Gastrointestinal (Heartburn, diarrhea, vomiting, abdomen pain)	€	€	_____________________
Urinary (Frequent or painful urination, incontinence, blood in urine)	€	€	_____________________
Musculoskeletal (Muscle aches, arthritis, swollen joints, gout)	€	€	_____________________
Skin (Rashes, excessive dryness, sore, itching)	€	€	_____________________
Neurological (Numbness, weakness, headaches, paralysis)	€	€	_____________________
Psychiatric (Depression, anxiety)	€	€	_____________________
Endocrine (Excessive hunger, thirst or sweating thyroid problems)	€	€	_____________________
Hematological/Lymphatic (Anemia, bruising, bleeding problems)	€	€	_____________________

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Consent for Treatment

I give my consent for necessary medical and surgical treatment, and the use of anesthetics or any medications deemed necessary for my care.

Insurance Authorization

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

Medicare

I request that payment of the authorized Medicare benefits be made on my behalf to BRANDYWINE PODIATRY for any services furnished about me be that group of physicians. I authorize any holder of medical information about me to be released to the benefits payable for related services.

I hereby authorize Medicare to furnish to BRANDYWINE PODIATRY any information regarding me Medicare claims under Title XVIII of the Social Security Act.

Commercial insurance

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE GROUP INDICATED ON THE CLAIM.

I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

The sheer volume of paper work and phone calls that are now being thrust upon physician's offices have become incredible. This particular office deals with over 200 insurance companies and therefore it is impossible to memorize each and every insurance plan. As a service to you, our office will gladly submit any covered visits or procedures to your insurance company. After a 30 day period we will inquire as to the status of all unpaid claims. Again in 30 days, an inquiry will be made. If at any time we have no results from the insurance company, the account will then be payable by the patient. It is the patient's ultimate responsibility to be aware of their insurance plan. Many insurance plans require patients to obtain referrals from their Primary Care Physician to use particular labs, hospitals, etc. You as the subscriber are responsible for your policy. We are trying to avoid confusion and financial hardships on you. Thank you for your attention and understanding.

Notice of Privacy Policies

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: (1) conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; (2) obtain payment from third party payers; and/or (3) conduct normal healthcare operations such as the quality assessments and physician certifications. I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how private information is used or disclosed to carry our treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I also understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I HAVE READ THE ABOVE AND I ACCEPT: CONSENT FOR TREATMENT, INSURANCE AUTHORIZTION, AND NOTICES OF PRIVACY POLICIES.	
SIGNATURE:	**Today's Date: / /**

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