ARCH AND SOLE PODIATRY CENTER

AYNE FURMAN, DPM

Patient Information Form

Today's Date:

Patient Information

NAME: LAST_____ M.I._____ FIRST_____

How do you prefer being referred to?_____ Date of birth_____

Address:_____ City_____

State_____ Zip Code_____ Email:_____

Home #_____ Cell # _____ Work #_____

Can phone messages be left on all the above numbers?

Sex: Male Female Status: Married Single Divorced Other

Employer's Name:_____ Occupation:_____

Spouse's or S.O. Name:_____

Can information regarding what Dr. Furman is treating you for be discussed with the above person? Yes No

In case of an emergency, contact:_____

Relationship_____ Phone #_____

How were you referred to Dr. Furman ?_____

What is the chief complaint that brings you to the office today?_____

Medical History

What is the name of your family physician?_____

Height: Weight: Approx. Shoe Size:

Have you had or currently have any of the below conditions? Check all that apply:

____Anemia ____Epilepsy/Seizers ____Heart Condition ____Arthritis (not rheumatoid)

___Rheumatoid or other auto-immune type of arthritis

___Lyme's Disease ___Fibromyalgia ____Chronic Fatigue syndrome

___Cancer ____Diabetes ___Blood clots (if yes, where was the clot?_____)

____Bleeding problems ____Breathing problems ____Heart Condition

____High Blood Pressure ____Infectious disease ____Kidney trouble

____Liver trouble ____Stroke

____ Stomach ulcers ____Joint replacement (Hip or Knee)

If you checked "yes" to any of the above, please explain if necessary:

Please list any allergies:

____None ____Anti-inflammatory medications (aspirin or Motrin type drugs)

____Codeine ____Cortisone ____Iodine ____Penicillin

____Metals (nickel, copper) ____Sulfa drugs ____Tape

____Latex or dyes ____Other medications:_____

Type of reaction/s experienced:

Do you smoke? Yes No Do you consume alcohol? Yes No

If female, are you pregnant? _____

Please list medication you are currently taking: _____

_____

Have you ever broken any bones? If yes, please list with approximate dates:

Any operations (excluding foot surgeries)? Yes No

Please list with approximate dates: _____

_____

Podiatric History:

Have you ever been treated for a foot, ankle or leg injury or pain in the past?

If yes, what was the diagnosis? Plantar fasciitis shin splints sprained ankle

neuroma uneven leg length heel spur bunion other:_____

Have you ever had foot surgery? If yes, what type and when?

____Bunionectomy ____Hammertoe surgery ____Neuroma surgery

____Metatarsal surgery ____Heel spur surgery

____Been treated for a foot ulcer ____Other:_____

Are you presently being treated by another health professional for this presenting problem? Yes No If yes, who?

Do you or have you ever used custom orthotics or foot levelers?

Is there personal or family history of diabetes?

Yes (Insulin dependent or Non-Insulin dependent) No

If yes, who?

Activity Profile:

I consider myself: Very active Moderately active Sort of active Sedentary

What fitness or athletic activities do you regularly participate in? How often? How many times a week? Check all that apply:

approximate # of times/wk	approximate # of times/wk
____Running	____Dancing
____Walking	____Aerobic dancing
____Walk the dog	____Yoga
____Tennis	____Golf
____Cycling/spin class	____Weight training
____Ballroom dance	____Soccer
____Soccer	____Other:_____

In the past year, have you had to stop activity for more than a week due to a foot, ankle, leg or knee pain or injury?

Do you regularly use a personal trainer? Yes No

Consent to treatment:

I hereby consent and give Dr. Ayne Furman my permission to administer and perform such procedures upon me as she deems necessary.

Signature of patient, parent or guardian:_____ Date:_____

Relationship to patient:_____

Financial and Insurance Information:

It has been explained to me that this is a fee for service practice. Payment is due at the time of service. Dr. Furman will supply me with the necessary forms and information to file a claim with my insurance company and/or MSA (medical savings account).

Dr. Furman is not responsible for knowing the terms of my insurance coverage or specific details regarding reimbursement coverage.

Dr. Furman is not a participating provider or in any contractual arrangement with any insurance carrier.

Patient's signature:_____ Date:_____

If you are insured by Medicare:

If I am a Medicare beneficiary I have been notified, and it has been explained to me that Dr. Furman does not participate with Medicare. This is referred to as *opt-out*. If you are a Medicare beneficiary charges for services preformed by Dr. Furman will be denied payment by Medicare.

Patient signature:_____

Patient's name:_____