Martin V. Sloan, DPM, FACFAS
Diplomate, American Board of Podiatric Surgery
Board Certified in Foot Surgery
www.DrMartinSloan.com

Patient Information

Patient's Name _____ Telephone _____

Home Address _____ City _____ State _____ Zip_____

Date of Birth _____ Age ____ Social Security No. ____-___-____ Driver's License No _____

Sex: M / F Marital Status S M D Sep W Email Address _____
Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Next of Kin _____ Employed by _____

Business Address _____ Business Phone _____

Who referred you to this office? Name _____ Address _____

What pharmacy do you use? _____

Insurance, Medicare Information

Company or Program Insured SS# / ID # Group Date of Birth (insured)

_____

_____

Authorization

Y Yes Y No I hereby authorize benefits directly to the physician of the surgical and/or medical benefits

Y Yes Y No I also understand I am responsible for any portion of my bill not covered by the insurance company

Y Yes Y No I HEREBY AUTHORIZE RELEASE OF INFORMATION FOR INSURANCE CLAIM PURPOSES

Y Yes Y No The information authorized for release may include information which may be considered communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV or AIDS

I understand all of the above and hereby state that the information is correct to the best of my knowledge

_____ _____ _____
Signature of Responsible Party if Other Than Patient Date Signature of Patient

Medical Information

Physician _____ City _____ Last Visit _____

Physician _____ City _____ Last Visit _____

Are you now, or have you been under a physician's care during the past 2 years? Yes No

Date of last complete physician examination _____

Are you under active care for diabetes? ☐ YES ☐ NO Circulation Problems? ☐ YES ☐ NO

If so, doctor's name _____ Last seen _____

Insulin Dependent ☐ YES ☐ NO Diet Controlled ☐ YES ☐ NO

No. years diabetic _____ Avg Blood Sugar Range _____

Review of Systems (check each item that applies to you)

CONSTITUTIONAL (GENERAL)

____ Weight loss/over 10 lbs	____ Weight gain/over 15 lbs	____ Fever	____ Chills
____ Fatigue	____ Nausea	____ Other _____	

EYES, EARS, NOSE & THROAT

____ Impaired sight	____ Eye disease	____ Eye pain	____ Vision problem
____ Eye infections-frequent	____ Glaucoma	____ Hearing loss	____ Ringing in ears
____ Ear infections	____ Dizzy spells	____ Fainting spells	____ Nose bleeds-frequent
____ Breathing difficulty	____ Sinus problems	____ Sore throat	____ Hoarseness
____ Speech difficulties	____ Dental problems	____ Abscessed (infected) teeth	
____ Other _____			

RESPIRATORY

____ Pneumonia/Pleurisy	____ Bronchitis/Chronic cough	____ Asthma/Wheezing	____ Shortness of breath
____ Tuberculosis	____ Emphysema	____ Hay fever/Allergies	____ Limited exercise tolerance
____ Use oxygen at home	____ C.O.P.D.	____ History of smoking	____ Other _____

CARDIOVASCULAR

____ Chest pain	____ Heart attack	____ High blood pressure	____ Open-heart surgery
____ Heart murmur	____ Chronic swelling ankles/feet	____ Palpitations	____ Irregular beat/pulse
____ Pacemaker	____ Mitral valve prolapse	____ Angioplasty	____ Artificial heart valve
____ Rheumatic fever	____ Circulation disorder	____ High cholesterol	____ Leg pain/walking
____ Leg pain/at rest	____ Tiredness in legs	____ Varicose vein	____ Phlebitis
____ Blocked arteries	____ Cold, numb feet	____ Angina - increased occurrence	
____ Angina-increased intensity	____ Angina-new onset at rest	____ Change in chest pain pattern	

____ Cardiac occlusive disease
____ Congestive heart failure
____ Other _____

GASTROINTESTINAL

____ Loss of appetite
____ Heart burn
____ Abdominal pain/chronic
____ Hepatitis A
____ Diarrhea
____ Heartburn/Refulx esophagitis
____ Excessive hunger
____ Peptic ulcer
____ Gallbladder problem
____ Hepatitis B
____ Diverticulosis
____ Other _____
____ Excessive thirst
____ Persistent nausea
____ Liver problem
____ Hepatitis C
____ Crohn's/colitis
____ Difficulty swallowing
____ Vomiting
____ Jaundice
____ Cirrhosis
____ Bloody or black stools

BLADDER, KIDNEY

____ Frequent urination
____ Renal failure
____ Bladder infections-frequent
____ Swelling feet
____ Blood in urine
____ Kidney stone

FEMALE

____ Sexual transmissive disease
____ Postmenopausal
____ Breast cancer
____ Oral contraceptives
____ Ovarian cancer

MALE

____ Sexual transmissive disease
____ Prostate cancer

HEMATOLOGIC (BLOOD DISORDERS)

____ Anemia
____ Sickle cell disease/trait
____ Bruise easily
____ Take Coumadin
____ Cancer
____ Blood transfusion

ENDOCRINE

____ Diabetes
____ Other _____
____ Thyroid disease

NEUROLOGICAL (NERVOUS)

____ Seizures
____ Change in memory
____ Numbness
____ Tremor/hands shake
____ Trouble with balance
____ Muscle weakness
____ Headaches-frequent
____ Spine disease
____ Polio
____ Stroke
____ Sciatica
____ Change in sensation

BONE AND JOINT

____ Arthritis/Rheumatism
____ Back pain-recurrent
____ Gout
____ Osteoporosis

____ Osteoarthritis ____ Rheumatoid arthritis ____ Artificial joints _____

____ Severe arthritis of TMJ (jaw) or neck

SKIN

____ Rashes ____ Hives ____ Psoriasis ____ Eczema
____ Skin cancer ____ New growths ____ Color change-mole/wart
____ Thick scar or keloid formation ____ Other _____

PSYCHIATRIC

____ Sleeping difficulty ____ Concentration difficulty ____ Depression ____ Nervousness
____ Agitation ____ Memory loss ____ Moodiness ____ Suicidal thoughts
____ Phobias ____ Mental illness ____ Feelings of worthlessness

CHILDHOOD ILLNESS

____ Rheumatic fever ____ Scarlet fever ____ Chickenpox ____ Mumps
____ Measles ____ Herpes

ALLERGY/IMMUNOLOGY

____ Hay fever ____ Grass, mold, dust ____ Food allergies ____ HIV
____ Weak immune system ____ Chronic fatigue syndromes ____ Frequent infections

HIV positive? ____ Yes ____ No Any infection/past 6 months? ____ Yes ____ No

Hepatitis ____ Yes ____ No Other (please specify) _____

Wound healing history _____

Do you have any artificial joints? Hip ___ Knee Other _____

Do you have a heart valve implant? ____ Yes ____ No

PLEASE CIRCLE ANY KNOWN ALLERGIES

Penicillin	Novocain	Codeine	Local anesthesia	Tape
Murcurials	Sulfa drugs	Aspirin	Other antibiotics	None

Other known allergies _____

PLEASE LIST ANY MEDICATIONS NOW BEING TAKEN (WITH DOSAGE)

Name of Medicine	Reason For Taking It	How Often Do You Take It?
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you taken Prednisone over the past 6 months? ___ Yes ___ No

PREVIOUS SURGERIES (WITH APPROXIMATE DATES)

_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY MEDICAL HISTORY

Mother	____	Living	____	Deceased	Cause of death _____
Father	____	Living	____	Deceased	Cause of death _____
Brother	____	Living	____	Deceased	Cause of death _____
Sister	____	Living	____	Deceased	Cause of death _____

Has anyone in your family ever been treated for:

	You	Father	Mother	Brother	Sister	Children	Grandparents	Aunt/Uncle
Arthritis	____	____	____	____	____	____	____	____
Cancer	____	____	____	____	____	____	____	____
Diabetes	____	____	____	____	____	____	____	____
Foot problems	____	____	____	____	____	____	____	____
Gout	____	____	____	____	____	____	____	____
Neuromuscular disease	____	____	____	____	____	____	____	____
Peripheral vascular disease	____	____	____	____	____	____	____	____
Tuberculosis	____	____	____	____	____	____	____	____
Varicose veins	____	____	____	____	____	____	____	____
Heart disease	____	____	____	____	____	____	____	____
Bleeding disorder	____	____	____	____	____	____	____	____
Stroke	____	____	____	____	____	____	____	____

Do you smoke? ___ Yes ___ No No. packs per day _____

Previously smoked? ___ Yes ___ No No. of years _____

Do you drink alcohol or beer? ___ Yes ___ No

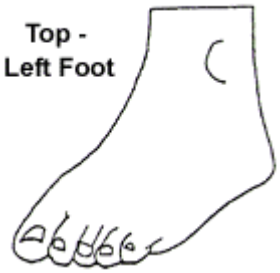
If yes, how much ___ 1-2/week ___ 1-2/day ___ more than 2 daily

DESCRIPTION OF PROBLEM

On the diagrams below, please mark the place(s) where you are experiencing pain in your feet:

Inside - Left Foot

Bottom -
Left Foot



Top -
Left Foot

Inside - Right Foot

Bottom -
Right Foot

Top -
Right Foot

Regarding the place(s) you marked above, describe the pain you experience, for instance, mild, moderate, severe, throbbing, burning, etc. and the time of day it occurs:

_____

_____

_____

DESCRIPTION OF PROBLEM (CONTINUED)

What is your foot problem? _____

_____

How long have you been bothered by foot problems? _____

How would you describe the pain you are having _____

_____

How is this condition limiting your activities? _____

_____

Have you seen another doctor for your foot problems? _____

Did you see a foot doctor or a family doctor? _____

Name of previous doctor who treated your foot problem _____

EMPLOYMENT HISTORY OF SHOES:

Employment: ___ sits at job ___ stands at job ___ stands & walks at job ___ retired

Does the employer require any particular type of shoes? Boots ___ Heels _____ Other ___ N/A __

After work: ___ goes home and sits ___ goes home and exercises Type of exercise _____

Length of time _____

Current weight _____ Current height _____

_____ _____

Signature Date

ASSIGNMENT OF INSURANCE REIMBURSEMENT

I assign the right to payment for all medical benefits directly to Martin V. Sloan, D.P.M., in consideration for medical services and supplies provided to me in pursuant to my health insurance plan.

In the event that my health insurance plan refuses to pay for medically reasonable and necessary services provided, I also assign all my ERISA* right to Martin V. Sloan, D.P.M. for a full and fair review of any and all denied claims, including any penalties that may be assessed against the insurance company for claims processing violations. This ERISA assignment is in consideration for unpaid services provided, in consideration for my insurance plan's reduced fee schedule, and in consideration for the continued willingness of Martin V. Sloan, D.P.M., to see patients, including me, on an insurance assignment basis. I understand that if my treating doctor prevails in any payment dispute, I may be liable for any applicable co-payment for contested services.

Initials :_____ **Date**: _____

RELEASE OF MEDICAL INFORMATION

I consent to release medical information to Martin V. Sloan, D.P.M. I consent to Martin V. Sloan, D.P.M. releasing medical information to other health care providers for the purpose of treatment when necessary for my care. I consent to allow Martin V. Sloan, D.P.M. to send all necessary medical information to my insurance plan.

I also consent to the release of medical information pertaining to the treatment by Martin V. Sloan, D.P.M. to those parties listed below.

Name: _____ Relationship:_____

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*ERISA is an acronym for the Employee Retirement Income Security Act which includes federal law offering insurance companies to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations may result in fines charged to the insurance company in amounts of up to $110 a day for each infraction.

Patient's Printed Named: _____

Patient's Signature: _____

Date: _____