

James P Hatfield, DPM inc
Diplomat, American Board of Podiatric Surgery
Fellow, American College of Foot Surgeons

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WELCOME TO OUR OFFICE Thank you for selecting our office to serve your foot care needs.

We will strive to provide you with the very best Podiatric care.

THANK YOU for taking the time to provide us this information which is needed to better serve you.

NAME _____ **BIRTH DATE** _____
ADDRESS _____ **PHONE** _____
CITY _____ **STATE** _____ **ZIP CODE** _____ **CELL PHONE** _____
ID CONFIRMATION _____ **DL#** _____ **ST** _____ **SS#** _____
OCCUPATION _____ **SINGLE** **MARRIED** **DIVORCED** **WIDOWED**

RESPONSIBLE PERSON _____ **RELATIONSHIP** _____
ADDRESS _____ **GUARDIAN SS#** _____
CITY _____ **STATE** _____ **ZIP CODE** _____ **PHONE** _____

EMPLOYER _____ **PHONE** _____
ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP CODE** _____

PRIMARY INSURANCE _____ **INS PHONE** _____
IDENTIFICATION # _____ **GROUP#/NAME** _____
SUBSCRIBER _____ **DATE OF BIRTH** _____
EMPLOYER (GROUP) _____ **EMPLOYER PHONE** _____

SECONDARY INSURANCE _____ **INS PHONE** _____
IDENTIFICATION # _____ **GROUP#/NAME** _____
SUBSCRIBER _____ **DATE OF BIRTH** _____
EMPLOYER (GROUP) _____ **EMPLOYER PHONE** _____

REFERRED BY _____ **RELATIONSHIP** _____
EMERGENCY CONTACT _____
RELATIONSHIP _____ **PHONE** _____

AUTHORIZED REPRESENTATIVE: *Written consent is required in order to disclose any medical or financial information to someone other than you. Please indicate to whom information may be disclosed.*

AUTHORIZED REPRESENTATIVE _____ **RELATIONSHIP** _____
 MEDICAL **FINANCIAL** **BOTH** **NO ONE IS AUTHORIZED** **PHONE** _____

MESSAGES: *Written consent is required in order to leave a **detailed** message on your voice mail or answering machine. Please indicate your preference type. You may also circle your preferred location.*

SIMPLE MESSAGE: Requesting a returned call or confirming an appointment.
DETAILED MESSAGE: Including medical and/or financial information.
HOME: Simple Detailed **WORK:** Simple Detailed **CELL:** Simple Detailed

FAX AND/OR EMAIL: *Written consent is required in order to **FAX and/or Email** any medical or financial information. If you wish to authorize a FAX and/or an Email ,please provide the information below.*

FAX _____
EMAIL _____

I certify that the above information is accurate and complete. I understand that I am personally responsible for payment of all fees incurred, and payment of fees is required at the time of service unless prior arrangements have been made. In the event of nonpayment, I agree to bear the cost of collection, court costs, and/or legal fees, including , but not limited to, a \$25.00 administrative fee. I authorize Dr. Hatfield to release information for the treatment of my condition, administration of my account or submission of insurance claims. I authorize my insurance company to send payment directly to Dr. James P Hatfield.

SIGNED _____ **DATE** _____

PAST MEDICAL HISTORY

NAME _____ DATE: _____

How did you hear of our office? _____ Relationship: _____

Physician: _____ Specialist: _____

Previous Podiatrist: _____

CURRENT MEDICAL PROBLEMS (please list if not listed below) NO MEDICAL PROBLEMS

CARDIOVASCULAR (please circle) NO CARDIOVASCULAR PROBLEMS

- | | | | |
|------------------|----------------------------|------------------|--------------------------------|
| Heart Attack | Angina (Chest Pain) | Rheumatic Fever | Raynaud's Syndrome |
| Heart Murmur | Heart Failure | Heart Disease | Mitral Valve Prolapse |
| Heart Surgery | Pacemaker | Hypertension | Anti-Coagulant Medication |
| Vascular Disease | Bleed Easily | Bruise Easily | Deep Vein Thrombosis/Phlebitis |
| Palpitations | Night Pain in Feet or Legs | Vascular Surgery | Leg Cramps with walking |

NEUROLOGICAL (please circle) NO NEUROLOGICAL PROBLEMS

- | | | | |
|------------|----------------------|-----------------------|------------------------------|
| Stroke | Epilepsy /Seizures | Mental Disorders | Loss of Sensation / Numbness |
| Depression | Dementia/Alzheimer's | Peripheral Neuropathy | Reflex Sympathetic Dystrophy |

GASTROINTESTINAL (please circle) NO GASTROINTESTINAL PROBLEMS

- | | | | |
|---------------------|--------------------|-----------|---------------|
| Stomach Ulcer | Intestinal Disease | Hepatitis | Liver Disease |
| Gastric Reflux-GERD | | | |

MUSCULOSKELETAL (please circle) NO MUSCULOSKELETAL PROBLEMS

- | | | | |
|---------------|----------------------|--------------------------------------|----------|
| Arthritis | Rheumatoid Arthritis | Artificial Joints | Sciatica |
| Back Problems | Gout | Implants in the Body (where?): _____ | |

SKIN (please circle) NO SKIN PROBLEMS

- | | | | |
|-------------|---------------|--------|--------------------------|
| Psoriasis | CRST Syndrome | Eczema | Venous Dermatitis – Legs |
| Skin Cancer | | | |

ENDOCRINE (please circle) NO ENDOCRINE PROBLEMS

- | | | |
|------------------|-------------------------------------|---------------------------------|
| Thyroid Problems | Diabetes (Type I or Type II) | Diabetes in Family (who?) _____ |
|------------------|-------------------------------------|---------------------------------|

OTHER (please circle) NO OTHER PROBLEMS

- | | | | |
|--------------------|----------------|--------------------------|------------------|
| Cancer _____ | Glaucoma | Kidney Disease | Lupus |
| Current Infections | MRSA Infection | Allergies / Hives | Organ Transplant |
| Venereal Disease | AIDS / HIV | Drug / Alcohol Addiction | |

CURRENT MEDICATIONS (please circle) NOT TAKING ANY MEDICATIONS

- | | | | |
|------------------------------|-----------------------|------------------------------|----------------------|
| Coumadin | Plavix | Aspirin | Ticlid |
| Vitamin E | Arthritic Medications | Antibiotics | Cortisone Medication |
| Anti-Inflammatory Medication | | Immunosuppressive Medication | |

Other Medication (please list): _____

ALLERGIES (please circle) NO KNOWN ALLERGIES

- | | | | |
|-------------|-------------|---------------|----------|
| Aspirin | Penicillin | Codeine | Vicodin |
| Demerol | Antibiotics | Sulfa Drugs | Novocain |
| Anesthetics | Iodine | Adhesive Tape | Latex |

Other Allergies (please list): _____

SOCIAL Do you drink alcohol? YES NO # Glasses/day _____

Do you **Smoke**? YES NO
Packs/Day _____

WOMEN ONLY Are you pregnant? YES NO If yes, which month? _____

Are you nursing? YES NO

I certify that the above information is **COMPLETE** and **ACCURATE**.

SIGNED: _____

DATE: _____