PATIENT INFORMATION SHEET

COLUMBIA PODIATRY

www.ColumbiaPodiatry.com

DANIEL A. B. METHUSELAH, D.P.M.

ONE WELLNESS BLVD., STE 102 • IRMO, SC 29063 • IRMO PROFESSIONAL CENTER 781-3500

WELCOME TO OUR OFFICE!

This Form Will Help the Doctor and his staff in preparing any insurance claims that you may need completed. Please answer all questions below. Thank you!

NAME _____ BIRTH DATE ____/____/____ AGE _____

ADDRESS _____ CITY / STATE _____ ZIP _____

SOCIAL SECURITY NUMBER _____/_____/_____ HOME PHONE _____ CELL _____

MARITAL STATUS M____ W____ S____ D____ REFERRED BY _____

ATTENDING MD (FAMILY DOCTOR) _____ DATE OF LAST VISIT _____

RESPONSIBLE PARTY (IF PATIENT IS A CHILD) _____ SS# _____ PARENT DOB _____

EMPLOYER _____ LENGTH OF EMPLOYMENT _____ YRS. _____ MOS.

EMPLOYER ADDRESS _____ TELEPHONE _____

SPOUSE'S NAME _____ EMPLOYER _____

IN CASE OF EMERGENCY, NOTIFY _____ TELEPHONE _____

NAME OF INSURANCE COMPANY _____

INSURED _____ INSURED'S DOB _____ POLICY NUMBER _____

OTHER INSURANCE / SECONDARY COVERAGE _____

INSURED _____ INSURED'S DOB _____ POLICY NUMBER _____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

____ YES NAME(S) _____

____ NO

Thank you for completing the above form. Please read the statements below, sign your name where indicated, and fill in the date. Thank you!

CERTIFICATION: I do hereby state that the information provided above is correct to the best of my knowledge.

PAYMENT GUARANTEE: I hereby agree to pay the established rates of this office for all services rendered to me or my dependents while I/they are under the care of Columbia Podiatry.

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION: I do hereby authorize Columbia Podiatry to permit any insurer providing me or my dependents under their care to inspect the medical record in connection with any charges arising from my treatment at this office. I further authorize any such insurer to pay directly to Columbia Podiatry, any payments for charges arising from services to me.

WITNESS: _____ DATE ____/____/____ SIGNED: _____

MEDICAL HISTORY INFORMATION SHEET

DATE____/____/____

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IMPORTANT! Please read the questions below carefully. Please answer all questions so that the Doctor can evaluate your problem in a most thorough manner, and provide you with the best possible care.

NAME _____

SEX_____ RACE _____ HEIGHT _____ ft. _____ in. WEIGHT _____ lbs. SHOE SIZE _____ length _____ width

WOMEN, ARE YOU PREGNANT? _____ ❑ YES If so, number of months _____ ❑ NO ❑ MAYBE

NATURE OF COMPLAINT/PROBLEM

RIGHT FOOT _____ ONSET _____ DURATION _____

LEFT FOOT _____ ONSET _____ DURATION _____

ASSOCIATED PROBLEMS _____

_____

PAST MEDICAL HISTORY

FORMER PODIATRIST _____ DATE OF LAST VISIT _____/_____/_____

ALLERGIES: (Check) ARE YOU ALLERGIC TO: ❑ NOVACAINE ❑ PENICILLIN ❑ IODINE ❑ ADHESIVE TAPE ❑ SULFA DRUGS

❑ OTHER MEDICATIONS (Name) _____

MEDICATIONS: (Current–name and dosage) _____

_____

_____

_____

HAVE YOU OR YOUR FAMILY EVER BEEN TREATED FOR ANY OF THE FOLLOWING CONDITIONS/PROBLEMS? (Check)

HEART PROBLEMS– ❑ YOU ❑ FAMILY; **KIDNEY PROBLEMS**– ❑ YOU ❑ FAMILY; **KELOID/HYPERTROPHIC SCARS**– ❑ YOU ❑ FAMILY;

LIVER PROBLEMS– ❑ YOU ❑ FAMILY; **STOMACH PROBLEMS**– ❑ YOU ❑ FAMILY; **HIGH BLOOD PRESSURE**– ❑ YOU ❑ FAMILY;

ARTHRITIS– ❑ YOU ❑ FAMILY; **BRUISE EASILY**– ❑ YOU ❑ FAMILY; **HEALING TIME**– _____YOU _____FAMILY; **CANCER**– ❑ YOU ❑ FAMILY;

ASTHMA– ❑ YOU ❑ FAMILY; **LUNG PROBLEMS**– ❑ YOU ❑ FAMILY; **EPILEPSY**– ❑ YOU ❑ FAMILY; **GOUT**– ❑ YOU ❑ FAMILY;

RHEUMATIC FEVER– ❑ YOU ❑ FAMILY; **AIDS OR RELATED DISEASES**– ❑ YOU ❑ FAMILY;

OTHER(S) _____

ARE YOU A DIABETIC ❑ NO ❑ YES IF YES, DATE OF LAST BLOOD SUGAR _____/_____/_____ RESULTS _____

OPERATIONS/ILLNESSES/INJURIES (Dates) _____

_____

HAVE YOU EVER RECEIVED GENERAL ANESTHESIA? ❑ NO ❑ YES ANY PROBLEMS? ❑ NO ❑ YES

DO YOU SMOKE? ❑ NO ❑ YES AMOUNT/DAY _____ PACKS DO YOU DRINK? ❑ NO ❑ YES AMOUNT/DAY _____

GENERAL AND INFORMED CONSENT FOR TREATMENT: I hereby request and authorize Columbia Podiatry, or its designee to administer treatment and to perform such general procedures as may be necessary in the diagnosis and treatment of my foot condition. I give my consent to have photographs and videotaped images made of my foot. I further certify that the information provided in the medical history above is true and accurate.

SIGNATURE:_____ WITNESS:_____ DATE____/____/____

PODIATRIC EXAMINATION TO BE COMPLETED BY THE DOCTOR

DATE____/____/____

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INTEGUMENT

	TEMP	MOISTURE	TURGOR	HAIR DIST.	COLOR
RIGHT					
LEFT					

❑ HYPERTROPHIC NAIL PLATE(S) ❑ DISCOLORATION NAIL PLATE(S)
❑ ONYCHOLYSIS ❑ ONYCHOCRYPTOSIS
❑ PARONYCHIA ❑ HAIR DIST.
❑ SUBUNGUAL DEBRIS

VASCULAR

(OUT OF FOUR)

	DORSALIS PEDIS A	POSTERIOR TIBIAL A	POPLITEAL A	CFT (sec)	VARICOSITES	EDEMA
RIGHT						
LEFT						

OTHER FINDINGS

NEUROLOGICAL

(OUT OF FIVE)

	MOTOR REFLEXES PATELLAR	ACHILLES	SHARP/DULL	LIGHT TOUCH	SENSORIUM MONOFILAMENT
RIGHT					
LEFT					

❑ SEE WEST TEST

OTHER FINDINGS

MUSCULO-SKELETAL

(OUT OF FIVE)

	MUSCLE STRENGTH INVERSION	EVERSION	DORSIFLEXION	PLANTARFLEXION	FOOT TYPE RECTUS	MILD PLANUS	MOD PLANUS	SEV PLANUS	MILD CAVUS	MOD CAVUS	SEV CAVUS
RIGHT											
LEFT											

OTHER FINDINGS

ADDITIONAL NOTES/FINDINGS:

(CONTINUED IN PROGRESS NOTES)

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GENERAL PROGRESS NOTES

PATIENT'S NAME _____ DOB ____/____/____ TEL. _____

ALLERGIES: _____ CHRONIC DISEASES: _____

INITIAL PROGRESS NOTES

XRAY STUDIES — SEE HISTORY AND PHYSICAL

❑ AP ❑ LAT ❑ OBL OTHER- ❑ TOES- ❑ FOOT- ❑ ANKLE-

FINDINGS: (1)

(2)

(3)

IMPRESSIONS: (1) (2)

(3) (4)

(5) (6)

RECOMMENDATIONS/ADVISE: ❑ NATURE OF ABOVE CONDITIONS, ETIOLOGY, AND TREATMENT MODALITIES AVAILABLE FOR SAME:

WRITTEN/ORAL INSTRUCTIONS/INFORMATION GIVEN RE:

❑ RE SHOE GEAR: ❑ RE SELF CARE:

❑ INJECTION (Dose/Site)

❑ DISPENSED

❑ Rx DISP. SIG.

❑ Rx DISP. SIG.

❑ Rx DISP. SIG.

❑ PARING OF LESIONS WITH SCAPEL

❑ MANUAL/MECHANICAL DEBRIDEMENT OF NAILS_____FT.

❑ OTHER

PTR_____ ❑ DAYS ❑ WEEKS ❑ MONTHS _____ DPM ____/____/____

ACKNOWLEDGMENT OF RECEIPT

OF

OFFICE POLICIES & PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Office and Financial Policies, as well as the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand these Policies.

_____ Date: _____

Patient Name (please print)

_____

Patient Signature

_____

Responsible Party

_____

Relationship to Patient