

**PAUL B. ROSS, D.P.M.**

Date Today: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail address (optional): \_\_\_\_\_

Date of Birth: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Patient's SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Gender: Male \_\_\_\_ Female \_\_\_\_ Marital Status: S \_\_\_\_ M \_\_\_\_ W \_\_\_\_ D \_\_\_\_

Patient's Employer: \_\_\_\_\_

Financially Responsible Party: \_\_\_\_\_ Phone: \_\_\_\_\_

.....  
Referred by: Doctor \_\_\_\_ Yellow Pages \_\_\_\_ Flyer \_\_\_\_ Family/Friends \_\_\_\_ Ins. Co. \_\_\_\_

Primary Care Physician (PCP): \_\_\_\_\_  
.....

**Primary Insurance:** \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder's Work Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's SSN: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder's Work Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's SSN: \_\_\_\_\_

I hereby authorize Dr. Paul B. Ross' office to submit claims to my Insurance Co. and to release any medical information necessary to process claims to my Insurance Co. I assign all medical benefits for services, supplies, & fees that are covered by my Insurance. I therefore agree to pay all deductibles, co-pays, non-covered services, & co-insurance percentages not paid by my Insurance. I understand that if I have no Insurance, payment in full will be expected at each visit, unless other arrangements are made.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent/ Guardian signature if patient is under 18)

In case of emergency please notify: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT MEDICAL HISTORY**

**Patient Name (please print)** \_\_\_\_\_ **Date:** \_\_\_\_\_

Current Foot Problems: \_\_\_\_\_

Location of pain: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Is condition related to work?  Yes  No If "Yes", please describe: \_\_\_\_\_

Type of Pain:  Throbbing  Burning  Tingling  Sharp  Shooting  Aching  Tender

Severity of Pain:  Mild  Moderate  Severe Numbness?  Yes  No

Do symptoms: Interfere w/ normal activities? \_\_\_\_\_ Interfere with wearing shoes? \_\_\_\_\_

Are you currently under a doctor's care for any other condition? \_\_\_\_\_

Have you or family members ever been treated for the following:

<u>Condition</u>	<u>You</u>	<u>Family</u>	<u>Condition</u>	<u>You</u>	<u>Family</u>
Stroke	_____	_____	Anemia	_____	_____
Phlebitis	_____	_____	Edema/ Swelling	_____	_____
Diabetes	_____	_____	Asthma	_____	_____
Hepatitis	_____	_____	Bronchitis	_____	_____
Gout	_____	_____	Varicose Veins	_____	_____
Ulcers of the Foot	_____	_____	Prolonged Bleeding	_____	_____
Leg Cramps/ Pain	_____	_____	Cancer	_____	_____
Heart Condition	_____	_____	Back Injury/ Pain	_____	_____
Heart Attack	_____	_____	Broken Bones	_____	_____
High/ Low Blood Pressure	_____	_____	Arthritis	_____	_____
Vascular Disease	_____	_____	Rheumatic Fever	_____	_____
Poor Circulation	_____	_____	Thyroid Disorder	_____	_____
Liver Disease	_____	_____	Osteoporosis	_____	_____
Kidney Disease	_____	_____	Keloid/ Thick Scar	_____	_____
Lung Disease	_____	_____	Other?	_____	_____

Do you have vascular grafts? Yes \_\_\_ No \_\_\_  
 Do you have joint implants? Yes \_\_\_ No \_\_\_  
 Do you have replacement heart valves? Yes \_\_\_ No \_\_\_  
 Have you had any serious illness or surgery? Yes \_\_\_ No \_\_\_

If "yes" please describe & give dates: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you currently pregnant? Yes \_\_\_ No \_\_\_  
 Do you smoke? Yes \_\_\_ No \_\_\_ How much?  
 Have you smoked in the past? Yes \_\_\_ No \_\_\_ How much?  
 Do you use alcohol? Yes \_\_\_ No \_\_\_ How much?

<u>Are you allergic to any medications?</u>	Yes	No
Penicillin	___	___
Other Antibiotics, Please List	___	___
Morphine	___	___
Codeine	___	___
Novocaine, Lidocaine, etc.	___	___
Aspirin	___	___
Tylenol	___	___
Advil, Aleve, Motrin, etc.	___	___
Sulfa Drugs	___	___
Iodine/ Betadine	___	___
Food Allergies	___	___
Other, Please List	___	___

Have you ever had reaction on adhesive tape? \_\_\_

Are you currently taking any medications? Yes \_\_\_ No \_\_\_ (please list drug, dosage & reason for use)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Physicians treating you for conditions listed above: \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_ Phone: \_\_\_\_\_

Is there anything else you would like the doctor to be aware of? \_\_\_\_\_

\_\_\_\_\_  
**Patient Signature** **Date**