PODIATRIC REGISTRATION AND HISTORY

INSTRUCTIONS:

You can type your information right into this form to complete it and press the Print Form button above

OR

press the Print Form button now for a blank form and complete the form in by writing in the information.

Please bring the completed form with you to your appointment.

THANK YOU!

PATIENT INFORMATION

Date ____________ SS/HIC/Patient ID# ____________

Patient Last Name ____________ First Name ____________ Middle Initial ______

Address ____________ City ____________ State ______ Zip ______

E-mail ____________

Sex ☐ M ☐ F Age ______ Birthdate ____________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer or School ____________

Address ____________ City ____________ State ______ Zip ______

Employer or School Phone ____________

Spouse's Name ____________ Birthdate ____________ SSN ____________

Whom may we thank for referring you? ____________

PHONE NUMBERS

Home Phone ____________ Cell Phone ____________

Best time and place to reach you ____________

IN CASE OF EMERGENCY, PLEASE CONTACT

Name ____________ Relationship ____________

Home Phone ____________ Work Phone ____________

INSURANCE

Who is responsible for this account ____________ Relationship to Patient ____________

Insurance Company ____________ Group # ____________

Is patient covered by additional insurance? ☐ Yes ☐ No Subscriber's Name ____________

Birthdate ____________ SSN ____________ Relationship to Patient ____________

Insurance Company ____________ Group # ____________

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with ____________ ____________
Name of Insurance Company(ies)

and assign directly to DR. KEVIN F. SUNSHEIN, D.P.M., Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE / MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to DR. KEVIN F. SUNSHEIN, D.P.M., Inc.. for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

____________ ____________

Signature of Beneficiary, Guardian or Personal Representative — Please print name of Beneficiary, Guardian or Personal Representative

Date ____________ Relationship to Patient ____________

CONTINUED NEXT PAGE

Centerville Location: 6474 Centerville Business Parkway, Centerville, OH 45459
PHONE: 937-435-7477 | FAX: 937-435-6644 | Web Site: WWW.SUNSHEINPODIATRY.COM | E-Mail: info@sunsheinpodiatry.com

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

Athletic activities in which you participate (please list and indicate frequency)

Have you ever been to a Podiatrist before? ☐ Yes ☐ No

If yes, please list Name ________ Last visit ________

Is there any personal or family history of diabetes? ☐ Yes ☐ No

Occupation ________

Cigarette/Tobacco use ________ Years smoked ________

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Calluses	☐ Yes	☐ No
Cramps or Numbness in Feet or Legs.	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Heel Pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Plantar Warts	☐ Yes	☐ No
Swelling Ankles or Feet	☐ Yes	☐ No
Tired Feet	☐ Yes	☐ No

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Allergies or Anesthetics	☐ Yes	☐ No	Eye Problems	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Allergies to Medicine or Drugs	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Foot or Leg Cramps	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Artificial Heart Valves or Joints	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Swelling in Ankles, Feet	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis or Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tired Feet	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Chronic Diarrhea	☐ Yes	☐ No	Neuropathy	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Ear Problems	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Surgeries you have had

Hospitalization other than for the surgeries listed

Family Physician ________ Last visit ________

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins	Dosage	Frequency

Pharmacy Name(s) ________ Pharmacy Phone(s) ________

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

☐ Adhesive Tape	☐ Local Anesthetics
☐ Anticoagulant Therapy	☐ Novocaine
☐ Aspirin	☐ Penicillin
☐ Codeine	☐ Seafoods
☐ Demerol	☐ Sulfa
☐ Iodine	

Other ________

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

____
Signature of Beneficiary, Guardian or Personal Representative

____
Please print name of Beneficiary, Guardian or Personal Representative

Date ________

Relationship to Patient ________

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