GARY N. SHIELDS, DPM

TODAY'S DATE: _____

FIRST NAME: _____ MIDDLE: ____ LAST NAME: _____

ADDRESS: _____ CITY: _____

_____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____ WORK: _____

PLEASE INDICATE WHICH NUMBER WHERE YOU PREFERRED TO BE REACHED.

SOCIAL SECURITY #: _____

DATE OF BIRTH: _____ AGE _____

EMPLOYER: _____

MARITAL STATUS: __ SINGLE __ MARRIED __ DIVORCED __ WIDOWED

SPOUSE NAME: _____ SPOUSE DATE OF BIRTH: _____

PRIMARY CARE PHYSICIAN: _____

NAME/PHONE OF CONTACT IN CASE OF EMERGENCY: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

WHAT IS YOUR FOOT PROBLEM? _____

WHEN DID IT START? _____

WHAT TREATMENT HAVE YOU TRIED? _____

ASSIGNMENT OF BENEFITS AUTHORIZATION

I request that payment of authorized insurance or Medicare benefits be made on my or my child's/children behalf to Gary N. Shields, DPM for any services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, including orthotics or inserts. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits. In Medicare assigned cases, the physician agrees to accept the charge of determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and/or noncovered services. I have been provided an opportunity to review the Notice of Privacy Practices. Do we have permission to speak with anyone concerning your medical condition? If yes, with whom?_____

I certify that the above information is true to the best of my knowledge. I give my permission to Gary N. Shields, DPM to diagnose and/or treat my feet and ankles.

X _____ _____
SIGNATURE OF PATIENT DATE

X _____ _____
PARENT OR AUTHORIZED REPRESENTATIVE (IF APPLICABLE) DATE

Gary N. Shields, DPM

WELCOME

Patient Name_____

Medical History

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

( ) yes ( ) no AIDS/HIV	( ) yes ( ) no Depression	( ) yes ( ) no Liver disease
( ) yes ( ) no Allergies to anesthetics	( ) yes ( ) no Diabetes	( ) yes ( ) no Low blood pressure
( ) yes ( ) no Allergies to medicines/drugs	( ) yes ( ) no Ear problems	( ) yes ( ) no Phlebitis
( ) yes ( ) no Anemia	( ) yes ( ) no Emphysema	( ) yes ( ) no Psychiatric care
( ) yes ( ) no Angina	( ) yes ( ) no Epilepsy	( ) yes ( ) no Radiation therapy
( ) yes ( ) no Arthritis	( ) yes ( ) no Eye problems	( ) yes ( ) no Rash
( ) yes ( ) no Artificial heart valve	( ) yes ( ) no Fainting	( ) yes ( ) no Respiratory Disease
( ) yes ( ) no Artificial joint	( ) yes ( ) no Fibromyalgia	( ) yes ( ) no Rheumatic fever
( ) yes ( ) no Asthma	( ) yes ( ) no Foot & leg cramps	( ) yes ( ) no Rheumatoid arthritis
( ) yes ( ) no Back problems	( ) yes ( ) no Gout	( ) yes ( ) no Shortness of breath
( ) yes ( ) no Bleeding disorder	( ) yes ( ) no Headaches	( ) yes ( ) no Sinus problems
( ) yes ( ) no Bronchial problems	( ) yes ( ) no Heart disease	( ) yes ( ) no Special Diet
( ) yes ( ) no Cancer	( ) yes ( ) no Hemophilia	( ) yes ( ) no Stroke
( ) yes ( ) no Chemical Dependency	( ) yes ( ) no Hepatitis or Jaundice	( ) yes ( ) no Swelling in ankles/feet
( ) yes ( ) no Chest pain	( ) yes ( ) no High blood pressure	( ) yes ( ) no Tuberculosis
( ) yes ( ) no Chronic diarrhea	( ) yes ( ) no High Cholesterol	( ) yes ( ) no Ulcers
( ) yes ( ) no Chronic Pain Syndrome	( ) yes ( ) no Hypothyroidism	( ) yes ( ) no Varicose veins
( ) yes ( ) no Circulatory problems	( ) yes ( ) no Kidney problems	( ) yes ( ) no Weight loss, unexplained

Additional past medical history:_____

Surgeries you have had:_____

_____

Hospitalization other than surgeries:_____

_____

Have you ever been under the care of any other doctor in the past 2 years? ( ) yes ( ) no

If yes please explain_____

Medications

(include prescription, over-the-counter & vitamins):

_____

_____

_____

_____

_____

Pharmacy name_____

Pharmacy Phone #_____

Do you take oral contraceptives? ( ) yes ( ) no

Allergies

( ) Adhesive tape	( ) local anesthetic
( ) Anticoagulant therapy	( ) Novocaine
( ) Aspirin	( ) Penicillin
( ) Codeine	( ) Seafoods
( ) Iodine	( ) Sulfa

Other_____