BERMUDA PODIATRY CENTRE

NEW PATIENT FORM - WELCOME TO OUR OFFICE

The completion of this form is the first step to experiencing the many benefits associated with Podiatry. Completion of this form will assist us in diagnosis and treatment, as well as helping to identify any possible risk factors to your foot health. All information, written or otherwise, that you give us is strictly confidential and is so treated by the entire staff.

Personal Details

Last Name: _____ First Name/M.I.: _____

Address: _____ Parish: _____ Postcode: _____

Mailing Address: _____

Home telephone: _____ Cell Phone: _____ Work :_____

Email Address: _____

Birthdate: Day _____ Month _____ Year _____ Sex: M F Marital Status: M S W D

How did you become aware of our clinic: _____

Employer: _____

Insurance Company: _____ Subscriber/Policy Holder: _____

Certificate #: _____ Group #: _____ Effective Date: _____

Next of Kin: _____ Next of Kin Phone #: _____ Relationship:_____

Reason for your visit

What is the main reason for your visit: _____

When did this begin: _____

How did this begin: _____

Has this occurred before: Yes / No If yes, when?: _____ Is it: Getting worse / Staying the same / Improving

Medical & Foot Health History

Please tick (✔) next to any condition you presently have. Please cross (**X**) next to any condition you have previously had:

Angina	Circulatory Problems	Heart Condition	In-grown ToeNail	Rheumatoid Arthritis
Ankle Injury	Corns/Callous	Heart Surgery	Knee Pain	Skin Condition
Ankle Pain	Cramps in legs	Heel Pain	Liver Disease	Slow Healing
Arch Pain	Diabetes	Hepatitis/Jaundice	Low Blood Pressure	Stroke
Arthritis	Epilepsy	High blood pressure	Neuropathy	Swelling in the feet
Asthma	Fainting	High Cholesterol	Numbness in the feet	Tired/Aching Feet
Bleeding Disorder	Flat feet	Hip Pain	Plantar Fasciitis	Leg/ Foot Ulcers
Blood Clot	Frequent Infections	H.I.V/ AIDS	Pregnancy	Varicose Veins
Bunions	Fungal Nail Infection	Itching/Rash on feet	Sciatica	Walking Problems
Cancer	Gout	Kidney Disease	Shin Splints	Warts

Other Health History (Please Specify): _____

Additional Health History

Have you had any fractures? Yes / No Details: _____

Are you currently taking any medications or supplements? Yes / No

Please List:

_____

Do you have any allergies or have you had any reactions to adhesive tape, latex, Iodine, local anesthetic or antibiotics?

Details: _____

General Practitioner Details

Name of Practitioner: _____ Do you consent that we communicate with your G.P. about your condition if necessary: Yes / No

Are you under other physical care? Yes / No If yes, name and profession of practitioner: _____

AUTHORIZATION TO RELEASE INFORMATION, INSURANCE BENEFITS AND BERMUDA PODIATRY CENTRE FINANCIAL POLICY.

I hereby authorize the practice to render podiatric medical services to me and to release any information regarding diagnosis and treatment of myself (my child or elderly relative) to my Insurance provider regarding my claim. Also by my signature I authorize payment directly to the Bermuda Podiatry Centre of benefits.

I agree that if I am an insurance patient that it is Bermuda Podiatry Centre's policy to file an insurance claim as a courtesy to me, if I have accurate and complete insurance information.

I understand that ***I am responsible for any amount not covered by my insurance company*** including any missed appointment charges for no shows, medical durable devices such as orthotics, and nail surgery procedures. I understand that co-pays are due on the date of service and that all overdue patient balances with more than 120 days outstanding may result in dismissal from the practice. I also understand that all legal costs and other expenses incurred in attempting to recover overdue amounts will be patient responsibility.

I understand that if I am a self pay patient, I am responsible for payment on the date of service.

Name of Patient/Guardian: _____ (Please Print)

Signature of Patient/Guardian: _____

Date: _____