

Joseph G. Burckhardt, DPM, PC

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to help you. We look forward to working with you in maintaining your health.

PATIENT INFORMATION

Patient's Name: <i>First</i> <i>Middle</i> <i>Last</i>	Patient's DOB: <i>(mm/dd/yyyy)</i>
Patient's Address:	Patient's Social Security: <i>(or last 4 digits)</i>
Patient's City/State/Zip:	Patient's Sex: <input type="checkbox"/> M <input type="checkbox"/> F <i>(please check one) ✓</i>
Patient's Primary Phone:	Patient's Marital Status: <i>(please check one) ✓</i> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other
Patient's Cell Phone:	
Name of Guarantor/Insured:	
Relation to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <i>(please check one) ✓</i> <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other <i>(please specify)</i>	Patient Referred By:
Guarantor/Insured DOB: <i>(mm/dd/yyyy)</i>	Patient's Employer:
Guarantor/Insured Social Security:	Patient's Work Phone:
Emergency Contact Name:	Patient's Email: <input type="checkbox"/> <i>(check here if NONE)</i>
Emergency Contact Phone:	Patient's Race: <i>(please check one) ✓</i> <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other Race
Caregiver (Decision Maker) Name:	
Caregiver Contact Phone:	Patient's Ethnicity: <input type="checkbox"/> Hispanic or Latino <i>(please check one) ✓</i> <input type="checkbox"/> Not Hispanic or Latino
Caregiver Relation to Patient:	Patient's Preferred Language:

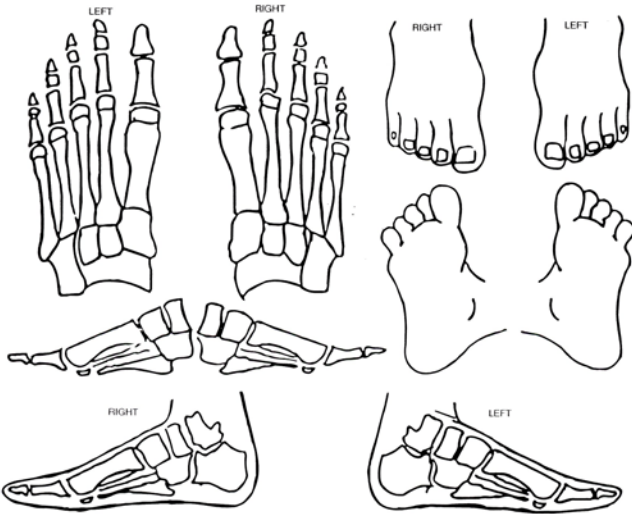
Please read authorization and HIPAA and sign below:

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor. I request that payments of authorized benefits be made on my behalf for any services furnished by Joseph G. Burckhardt, DPM. I authorize the doctor to obtain or release all health information necessary for my treatment and to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due in full at time of treatment unless prior arrangements have been approved.

Signature: _____ **Date:** _____

(Please check relation to Patient: Patient Parent/Guardian Caregiver)

PATIENT PODIATRIC AND HEALTH INFORMATION



What is the nature of your foot problem? _____

(Use diagram at left to indicate where you are experiencing a problem.)

Primary Care Physician: _____

Date of last visit (MM/DD/YY): _____

Pharmacy: _____

Location/Phone Number: _____

Height: _____ Weight: _____ Shoe Size: _____

Are you in good general health? Yes No

If no, explain: _____

Do you use tobacco products? Never Formerly (When did you stop? _____) Currently (What amount daily? _____)

Have you had previous foot/ankle surgery? Yes No If yes, describe: _____

Please list any other surgeries you have had, and dates (can be approximate, e.g. MM/YY): _____

Is today's visit related to: Employment Yes No Auto Accident Yes No Other Accident Yes No

Check (✓) Yes or No as to whether you have had or currently have any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes (Ins. Dep.) | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Trouble |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes (Non-Ins. Dep.) | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Trouble |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatism |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Atopic (Allergy Prone) | <input type="checkbox"/> Yes <input type="checkbox"/> No Eye Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of Breath |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach/GI Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Circulation Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No Swelling (Feet/Ankles) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cramps/Numbness | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Varicose Veins |

Please list any allergies to **medications** or other allergens: _____

Please list any medications (prescription, over the counter, supplemental, etc.) you now take or have taken for more than two weeks, including dosage information:

Please Read Attestation and Sign Below:

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Signature: _____ Date: _____

(Please check relation to Patient: Patient Parent/Guardian Caregiver)