



Patient's Name: _____ Date of Birth: _____

MEDICAL HISTORY

Please check "Yes" or "No" to indicate if you have or have had any of the following:

- | | | | | | |
|--------------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Plantar Warts | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ankle Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Flat Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Foot or Leg Cramps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves/Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Athlete's Foot | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heel Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bunions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis or Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling in Ankles or Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ingrown Toenails | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tired Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chronic Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Varicose Veins | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Corn and Calluses | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Numbness in Feet/Legs | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ear Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Phlebitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

Do you take oral contraceptives? Yes No

ALLERGIES

Adhesive/Tape Novocaine

Aspirin Penicillin

Codeine Sulfa

Demerol Seafood

Iodine

Anticoagulant Therapy

Local Anesthetics

Other _____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient or Parent/Guardian Signature: _____

Date: _____

**AUTHORIZATION AND ASSIGNMENT
OF BENEFITS**

1. Assignment is hereby made to the benefit of every and all insurance rights or benefits the undersigned may have and to any settlements from third party claims to the extent of all bills for services rendered.
2. I authorize this office to release any information to any insurance company, adjuster, collection agent or attorney that will assist in the payment of a claim.
3. I fully understand and agree that the insurance policies are an arrangement between an insurance carrier and myself. I will be responsible for any expenses the insurance carrier does not meet, including deductibles, co-payments and non-covered expenses.
4. In the event that non-payment of the account results in the account being referred to an outside agency for collection, the parties hereto agree that in addition to the existing balance, the collection fee charged by the collection agent or attorney of 33-1/3% will be added to the balance and shall be due and payable.
5. A photocopy of this form shall be considered as valid as the original.
6. Payment is expected when services are rendered unless prior financial arrangements have been made. There will be a \$25.00 service charge on all returned checks.
7. Twenty-four (24) hour notice must be given to the office for all cancelled appointments.
8. I hereby give Chesapeake Foot and Ankle Center, W. Scott Wooddell, D.P.M., permission to examine and treat my feet.

Patient or Parent/Guardian Signature: _____

Date: _____

MEDICAL AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to W. Scott Wooddell, D.P.M. for any services furnished me by that physician. 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 or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to apply the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: _____

Date: _____