

Lafayette Podiatry Associates, P.C.

415 North 26th Street, Suite 305
Lafayette, IN 47904
(765) 449-4758

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PATIENT INFORMATION

Patient's Last name:		First:	Middle:	Sex:	Is the patient a minor?	
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, additional forms may be required.	
Social Security no.:	Birth date:	Age:	Email:			
	/ /					
Street address:		Apt. no.:	City:	State:	Zip Code:	
Home phone no.:	Work phone no.:	Cell phone no.:	Preferred Pharmacy & Location:			
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Primary Physician:	Emergency Contact:	Emergency Contact phone no.:	Primary Language:			
		()				
Race (circle one): American Indian Asian Pacific Islander African American Caucasian Other _____					Ethnicity (circle one): Hispanic/Latino Non-Hispanic/Non-Latino	
Referring Physician:	Marital status (circle one):	Student status (circle one):	Employment status (circle one):			
	Single Mar Div Wid	Part-time Full-time N/A	Part-Time Full-time Retired N/A			
Employer:			Employer phone no.: ()			
Preferred form of contact (circle one): Phone Mail Email			Whom may we speak with (circle one): Patient Patient or Spouse Anyone			

INSURANCE INFORMATION

Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____				Policy no.:	
Subscriber's name:	Subscriber's address (if different):	State:	ZIP code:	Subscriber's phone no.:	
				()	
Subscriber's birth date:	Subscriber's S.S. no.:	Subscriber's gender:	Subscriber's Employer:	Employer's phone no.:	
/ /		<input type="checkbox"/> M <input type="checkbox"/> F		()	

BILLING INFORMATION (POA, LEGAL GUARDIAN, ETC.)

Full Name:	Birth date:	Address (if different):	Home phone no.:
	/ /		()

ATTENTION

- I authorize the release of all information to my insurance companies, workers compensation carriers, and/or other treating physicians.
- I authorize and request insurance payment directly to Lafayette Podiatry Associates, P.C.
- I understand that I am responsible for my bill.
- I authorize use of this form on all of my insurance submissions.
- I authorize Lafayette Podiatry Associates, P.C. to act as my agent in helping obtain payment from my insurance companies and to help me obtain any required pre-certification.
- I agree to pay for my bill in full plus court costs, attorney fees, and all collection fees if deemed necessary.
- If insurance deems my procedure medically unnecessary, I will be responsible for payment.
- I authorize treatment of my foot/ankle problems by physicians of Lafayette Podiatry Associates, P.C..

SIGNATURE REQUIRED

Patient/Guardian signature

Date

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Medical History

Patient Name: _____ Date: _____

Height: _____ Weight: _____ Shoe Size: _____ Do you have Diabetes? Y N

What type of foot/ankle problem are you having? _____

Do you smoke? Y N Packs per day: _____ Number of Yrs: _____

Do you use alcohol? Y N If yes, please circle how often? Rarely Often Socially

Do you exercise and/or play sports? (please list): _____

Medications:

<u>Drug Name</u>	<u>Dose</u>	<u>Times Per Day</u>	<u>Drug Name</u>	<u>Dose</u>	<u>Times Per Day</u>

Allergies:

<u>Drug or Medication Name</u>	<u>Reaction or Side Effect</u>

Patient Name: _____ Date: _____

Surgical History:

<u>Operation</u>	<u>Year</u>	<u>Operation</u>	<u>Year</u>

Personal/Family Medical History:

(please mark with an (√) a history of the following with either yourself or other family member)

<u>Medical Condition</u>	<u>Self</u>	<u>Other</u>	<u>Medical Condition</u>	<u>Self</u>	<u>Other</u>
Anemia			Heart Murmurs		
Arthritis			Heart Palpitations		
Asthma			Hepatitis		
Cancer (Skin)			Hernias		
Cancer (Other) <small>List:</small>			High Blood Pressure		
Chronic Abdominal Pain			High Cholesterol		
Chronic Chest Pain			HIV/AIDS		
Chronic Cough			Injury/Fracture		
Chronic Heartburn			Kidney Disease		
Colitis			Liver Disease		
COPD			Low Back Pain/Trauma		
Diabetes, Type I			Muscle Joint Pain		
Diabetes, Type 2			Nervous System Problems		
Epilepsy (seizures)			Osteoporosis		
Fevers/Chills/Night Sweats			Rheumatoid Arthritis		
Frequent Nausea/Vomiting			Stroke		
Gastrointestinal Problems			Thyroid Disorder		
Gout			Total Joint Replacement		
Heart Attacks			Ulcers		