

Welcome

Honeygo Podiatry

Edward S. Orman, DPM, PA

Name _____ SS# _____
Last First Middle

Address _____ APT _____ Date of Birth ____ / ____ / ____

City _____ State _____ Zip Code _____ Marital Status S M D W
Circle One

Home Phone _____ Cell Phone _____ Sex M F
Circle One

Employer _____ Phone _____

Address _____

Physician _____ Phone _____

Address _____

Who Referred you to our office? _____

Whom Should We Notify In Case Of Emergency?

Name _____ Relationship _____

Address _____ Home Phone _____

City _____ State _____ Zip Code _____ Work Phone _____

PRIMARY INSURANCE

Company _____ Policy Holder's Name _____ SS# _____

Address _____ Date of Birth _____ Policy # _____

Employer _____ Group # _____

Insurance Co Phone # _____

SECONDARY INSURANCE

Company _____ Policy Holder's Name _____ SS# _____

Address _____ Date of Birth _____ Policy # _____

Employer _____ Group # _____

Insurance Co Phone # _____

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Orman or any members of his staff responsible for any errors or omissions that I may have made. I am fully aware that there is a \$5.00 per month rebilling fee on all unpaid balances. All returned checks are subject to a \$25.00 fee.

Signature _____ Date _____

Insurance Authorization and Assignment

I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits directly to Edward S. Orman, DPM, PA for myself or my dependents. I understand that I am responsible for any deductibles, coinsurance, copays, or other amounts not covered by my insurance companies. If a referral is required and is not presented at the time of service, I will be responsible for payment.

Signature _____ Date _____

PODIATRIC HISTORY

What is the chief complaint for which
You came to be treated? _____

Please indicate which foot problems
you now have or had in the past.

- Ankle pain
- Athletes foot
- Bunions
- Corns, calluses
- Cramps or numbness in feet or legs
- Flat feet
- Heel pain
- Ingrown toenails
- Warts
- Swelling feet/ankles
- Tired feet

Have you ever been to a podiatrist before?
 Yes No

If yes, please list:

Name _____

SOCIAL HISTORY

Your occupation _____

Smoke cigarettes _____ if yes how
many packs per day and for
how long _____

Athletic activities in which you
participate (please list and indicate
frequency) _____

MEDICAL HISTORY

Check symptoms you currently have or had in the past year

GENERAL

- Chills
- Depression/Nervousness
- Dizziness/Fainting
- Fever
- Forgetfulness
- Headache
- Loss of Sleep
- Numbness
- Sweats

Gastrointestinal

- Poor appetite
- Vomiting blood
- Bowel changes
- Excessive thirst
- Gas
- Hemorrhoids
- Nausea/Vomiting
- Rectal bleeding
- Stomach pain

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Ear ache/discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nose bleeds
- Persistent cough
- Ringing in ears
- Vision flashes/halos
- Sinus problems

MEN ONLY

- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other _____

WOMEN ONLY

- Abnormal Pap smear
- Bleeding betw. periods
- Breast lump
- Ext. menst. pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other _____

MUSCLE/JOINT/BONE

- Pain, weakness, numbness in:
- Arms Hips
 - Back Legs
 - Feet Neck
 - Hands Shoulders

CARDIOVASCULAR

- Chest pain
- High/low Blood pressure
- Irregular/rapid heart beat
- Poor circulation
- Swelling ankles
- Varicose veins

SKIN

- Bruise easily
- Hives
- Itching/rash
- Change in moles
- Scars
- Sore that won't heal

GENTO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

Check conditions you have or had in the past

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Prostate problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal disease |

Medications

list any medications you take

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Medication Allergies

List any medication allergies and the reaction

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Health Habits

check all substances you use and how much

- Caffeine _____
- Drugs _____
- Tobacco _____
- Other _____

check if your work
exposes you to the
following:

- Stress
- Heavy lifting
- Hazardous substances
- Other _____

I certify that all the above information is correct to the best of my knowledge. I will not hold my Dr. Orman or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Name (please print clearly) _____

Signature _____ Date _____