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: *First* *Middle* *Last*	**Patient's Primary Care Physician :** *(PCP)*
Patient's Address:	**Date of Last Visit with PCP:** *(mm/dd/yyyy)*
Patient's City/State/Zip:	**Patient Referred By:**
Patient's Primary Phone:	**Patient's DOB:** *(mm/dd/yyyy)*
Patient's Cell Phone:	**Patient's Sex:** *please check one ✓* ☐ M ☐ F
Patient's Work Phone:	**Patient's Marital Status:** *please check one ✓* ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
Name of Guarantor/Insured:	**Patient's Social Security:** (or last 4 digits)
Relation to Patient: *please check one ✓* ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other *(please specify)*	**Patient's Employer:** **Patient's Pharmacy:**
Guarantor/Insured DOB: *(mm/dd/yyyy)*	**Patient Pharmacy Phone Number:**
Guarantor/Insured Social Security:	**Patient's Email:** *If NONE, check here*
Emergency Contact Name: **Emergency Contact Phone:** **Caregiver (Decision Maker) Name:**	**Patient's Race:** *please check one ✓* ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
Caregiver Contact Phone:	**Patient's Ethnicity:** *please check one ✓* ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Caregiver Relation to Patient:	**Patient's Preferred Language:**

Please read authorization and HIPAA and sign below:

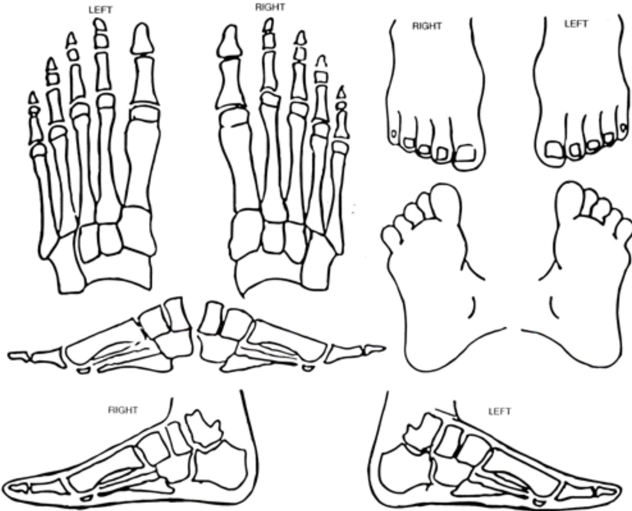
I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor. I request that payments of 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)

Joseph G. Burckhardt, DPM, PC **Patient Name:**______________________________

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.)

Height:_________________________

Weight:_________________________

Shoe Size:_______________________

Are you in good general health? ☐ Yes ☐ No

If no, explain:____________________________________

____

Do you use tobacco products? ☐ Currently ☐ Formerly ☐ Never Used If yes, 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:

☐ Yes ☐ No Anemia	☐ Yes ☐ No Diabetes (Ins. Dep.)	☐ Yes ☐ No Kidney Trouble
☐ Yes ☐ No Arthritis	☐ Yes ☐ No Diabetes (Non-Ins. Dep.)	☐ Yes ☐ No Liver Trouble
☐ Yes ☐ No Asthma	☐ Yes ☐ No Epilepsy/Seizures	☐ Yes ☐ No Rheumatism
☐ Yes ☐ No Atopic (Allergy Prone)	☐ Yes ☐ No Eye Trouble	☐ Yes ☐ No Shortness of Breath
☐ Yes ☐ No Bleeding Disorder	☐ Yes ☐ No Fainting Spells	☐ Yes ☐ No Stomach/GI Problems
☐ Yes ☐ No Cancer	☐ Yes ☐ No Gout	☐ Yes ☐ No Stroke
☐ Yes ☐ No Circulation Problems	☐ Yes ☐ No Heart Trouble	☐ Yes ☐ No Swelling (Feet/Ankles)
☐ Yes ☐ No Cramps/Numbness	☐ Yes ☐ No High Blood Pressure	☐ Yes ☐ 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:

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 authorize the doctor to obtain or release all health information necessary for my treatment and to secure the payment of benefits.

Signature:____ Date:______________________

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