

**All Colorado
Podiatry Group**

Dr. James Dill
Dr. Raman Sinha



Southwest Foot Clinic
6169 S Balsam Way Suite 320
Littleton, CO 80123
303-973-3668

Washington Park Foot Clinic
1501 S Gaylord Street
Denver, CO 80209
303-733-1473

Patient's Name _____
Marital Status (circle): Single Married Widowed Divorced
Social Security No. _____
Street Address _____
City, State, Zip _____
Mobile Phone _____
Employer _____
Employer Address _____

Today's Date _____
Birth Date _____ Age _____
Gender (circle): Male Female
Best Phone _____
Email _____
Work Phone _____
Occupation _____

Family Doctor _____ Location _____ Phone _____
Last visit to family doctor ___/___/___ Why? _____
Emergency contact (Name) _____ Relationship _____ Phone _____
Others we may discuss your medical history with _____ Phone _____
You may leave messages or appointment reminders at my phone number at: ___Home ___Work ___Cell ___Other: _____

Name of Insured _____ Insurance company _____
Whom may we thank for referring you to our office? Dr. _____ at _____
(or Circle) Internet Search Yellow Pages Insurance Company Directory Other _____

A word about insurance: Insurance coverage is a contract between you and your insurance company. The doctor does not determine the amount to be paid. The fees or any remaining balance due after the payment of primary insurance benefits is your responsibility. X _____

Release: I give the doctor permission to release information for the insurance processing of my claim and to release information to my physician and associated medical personnel. X _____

Authorization: I authorize payment of medical benefits to the undersigned physician or supplier for the services performed today. Acknowledgement: I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice. X _____

Patient or Authorized Representative

Signature

Date

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Reason For Today's Visit: _____

Medicines (including vitamins, herbals, etc.)

Medical Problems (why are you taking the medicines?)

Allergies: None Penicillin Iodine Shellfish Tape Codeine Sulfa Novocaine Other _____

Surgeries: None _____

Family History (do blood relatives have any of the following problems?): Arthritis, Diabetes, Cancer, Heart Disease, High Blood Pressure, Poor Circulation, High Cholesterol, Foot Problems, Stroke, Neuropathy, Obesity, Other

Mother Living Deceased Age ___ Medical Problems _____

Father Living Deceased Age ___ Medical Problems _____

Brothers Living Deceased Age ___ Medical Problems _____

Sisters Living Deceased Age ___ Medical Problems _____

Children Ages _____ Medical Problems _____

Social History: Daily Caffeine? No Yes ___ Daily Servings _____ Tobacco? No Yes ___ Packs x ___ Years _____

Alcohol? No Yes ___ Servings per Day Week Month _____ Recreational Drugs? No Yes Type _____

Work Duties/Social Activities _____

Height: _____ Weight: _____ Weight 1 year ago: _____

Review of Systems (Circle symptoms that you have had in the recent past)

HEENT: Seasonal allergies, Corrective lenses, Balance issues, Hearing loss, Recent cold

Cardiovascular: Chest pain, Blood Clots, Pacemaker

Respiratory: Shortness of breath, Blood in sputum

Gastrointestinal: Nausea, vomiting, diarrhea, constipation, appetite changes, stomach ulcer, frequent thirst

Genitourinary: Excessive urination, Miscarriage, c-sections

Musculoskeletal: Foot pain, arthritis, rheumatic disease, calf pain, joint pain, broken bones

Integumentary: Easy bruising, skin ulcers, open ulcers, skin infections, rashes, athlete's foot

Neurologic: Numbness, weakness, seizures, tremors, forgetfulness

Psychiatric: Anxiety, Depression, loss of appetite, Psychiatric care

Endocrine: Hypo or Hyperthyroid, unwanted recent weight loss or gain

Other: Symptoms or Issues Not Discussed Elsewhere: _____

Patient Name

Patient Signature

Date