Aboite Podiatry Associates, P.C.
7559 West Jefferson Blvd., Fort Wayne, IN 46804
P: 260-436-3579
F: 260-459-0287
W: www.aboitepodiatry.com

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Occupation:	Height:	Weight:	Shoe Size:
Primary Care Physician:		Date of last visit:	
Cardiologist:		Date of last visit:	
Endocrinologist:		Date of last visit:	
Pharmacy:	Location:		

Social History

Do you smoke?	☐ Yes, ( ) number of packs per day	☐ No
Do you drink alcohol?	☐ Yes, (list # drinks/frequency)	☐ No
Do you take recreational drugs?	☐ Yes, (list types)	☐ No
Do you actively participate in sports?	☐ Yes, (list types)	☐ No
Are you pregnant?	☐ Yes	☐ No

Physical History (Check all that apply)

☐ Aids	☐ Difficulty Breathing	☐ Malaria	☐ Polio
☐ Alzheimer's	☐ Diphtheria	☐ Measles	☐ Raynaud's Disease
☐ Anemia	☐ Epilepsy	☐ Mitral Valve Prolapse	☐ Rheumatic Fever
☐ Aneurysm	☐ Glaucoma	☐ Mumps	☐ Scarlet Fever
☐ Ankle Swelling	☐ Gout	☐ Muscular Weakness	☐ Sleep Apnea
☐ Arthritis	☐ Headaches	☐ Narcolepsy	☐ Stomach Ulcer
☐ Asthma	☐ Hepatitis	☐ Neurological Problems	☐ Stroke
☐ Blood Clots	☐ Heart Disease	☐ Osteoporosis	☐ Thyroid Disorder
☐ Blood Disorder	☐ High Blood Pressure	☐ Palpitations	☐ Tuberculosis
☐ Bleeding Tendency	☐ Kidney Disease	☐ Paralysis	☐ Venereal Disease
☐ Cancer (specify type)	☐ Liver Disease	☐ Parkinson's	☐ Other (specify)
☐ Chicken Pox	☐ Low Back Pain	☐ Peripheral Vascular Disease	
☐ Diabetes	☐ Lupus	☐ Pleurisy	

Have you had problems with any of the following? (Check all that apply)

Eyes:	☐ Macular Degeneration	☐ Cataracts	☐ Contacts	☐ Glasses	☐ Glaucoma
Head:	☐ Concussion	☐ Hearing Aids	☐ Hearing Loss	☐ Meniere's	☐ Trauma
Ears:	☐ Ringing of Ears	☐ Vertigo			
Nose:	☐ Allergies	☐ Sinus			
Throat:	☐ Cancer	☐ Strep Throat	☐ Tonsilitis		
Lungs:	☐ Cancer	☐ Emphysema	☐ Shortness of Breath		
GI:	☐ Crohn's	☐ GERD	☐ Intestinal Problems	☐ IBS	☐ Ulcer
Skin:	☐ Non-healing Sores	☐ Eczema	☐ Psoriasis		
Joints:	☐ Degenerative Arthritis	☐ Gout	☐ Joint Implants	☐ Rheumatoid Arthritis	
Muscles:	☐ Fibromyalgia	☐ Multiple Sclerosis	☐ Muscular Dystrophy		

☐ Other/Additional Info

_____

_____

_____

Patient Name: **Date of Birth:**

Present Medical Conditions (list)

Family History (Check all that apply)

☐ Arthritis ☐ Heart Disease
☐ Blood Disorder ☐ High Blood Pressure
☐ Cancer ☐ Kidney Disease
☐ Diabetes ☐ Liver Disease
☐ Foot Disorder ☐ Other (specify)

Injury History (Please list all broken bones, sprains, etc.)

Do you have any pins, screws, plates, or implants?	☐ Yes (list)	☐ No
Do you have any joint replacements?	☐ Yes (list)	☐ No
Do you have a pacemaker?	☐ Yes (list)	☐ No

Surgical History (Please list **ALL** surgeries and any anesthesia complications)

Present Medications

Please list all medication dosages, including over-the-counter medications (Ginkoba, Aspirin, Vitamins, etc.)

Allergies or Medicines Not Tolerated (Please list all known allergies and **type of reaction**)

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Patient Information

Last Name:	First Name:	MI:
Date of Birth:	Social Security Number:	☐ Male ☐Female
Address:		
City:	State:	Zip code:
Primary Phone:	Secondary Phone:	
Email address: *(required to access the patient portal)*		
Statement Preference: ☐ Email ☐ Text ☐ Paper Only		
Preferred Language:	Ethnicity:	Race:
Occupation:	Employer Name:	

Marital Information

Marital Status: ☐ Single	☐ Separated	☐ Married	☐ Divorced	☐ Widowed
Spouse/Partner Name:	Date of Birth:	Phone Number:		

Responsible Party Information (if patient is under 18)

Parent/Legal Guardian Name:	Date of Birth:
Relationship to Patient:	Phone Number:

Insurance Policy Holder

Policy Holder Name:	Date of Birth:
Relationship to Patient:	

In Case of Emergency

Name:	Relationship to Patient:
Phone Number:	

Signature: **Date:**

tjm 12-4-23

Aboite Podiatry Associates, P. C.

I authorize Aboite Podiatry Associates to release any of my medical records or information needed for this or a related claim. I permit a copy of this information to be used in place of the original, and request payment of insurance benefits to the party who may or may not accept assignment.

*If enrolled in the Medicare program: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Aboite Podiatry Associates, for any services furnished me by or in Aboite Podiatry Associates, PC, including physician's services. I authorize any holder of medical or other 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 authorize the release of medical information to other medical personnel for the sole purpose of medical management of my health. I understand that I may REVOKE this authorization at any time, in writing. I understand that I am giving permission to release medical information.

Signature: **Date:**

I hereby give Dr. Matthew Robison, Dr. Jacqueline Monroe, Dr. William Arthur and/or such assistants as may participate with her/him, my permission and consent to perform diagnostic tests and administer therapeutic treatment including medications and minor procedures as may be deemed necessary in the diagnosis and/or treatment of my foot/ankle condition. I understand that there are always potential complications associated with any treatment and that there are no guarantees being made.

Signature: **Date:**

I acknowledge and understand the following:

- I may be charged for any missed appointments, if 24-hour notice is not properly given. I may call, leave a voicemail, text, email, or properly respond to the appointment reminder system at any time prior to the day of my appointment to cancel within the policy guidelines.
- I am responsible for providing current and valid insurance information, including an insurance card, within the timely filing limits of my insurance carrier.
- Insurance precertification or authorization may be required for services and I take responsibility to verify that services have been authorized when required. I understand that it is my responsibility to determine if podiatric benefits are included in my individual health insurance policy.
- I am responsible for all of my copayment, coinsurance, deductible, and excluded services as set by my health insurance carrier, as well as charges for medical leave paperwork and disability forms, and medical records requests not related to coordination of care, transfer of medical care, authorization of services or prescriptions, or insurance payments.
- Aboite Podiatry Associates may receive remuneration for treatments and products prescribed and/or recommended to me.
- Entering into a payment plan agreement outside of the standard 90-day arrangement may be subjected to an interest fee of 1.5% monthly or the maximum allowed by law, whichever less.
- I am responsible for any and all collection charges incurred, which includes 35% of my outstanding balance as well as court costs and attorney fees should collection procedures be necessary.
- The fees charged are usual, customary, and reasonable for the region. I understand that contracted insurance carriers have maximum allowed amounts and varying coverage criteria that Aboite Podiatry Associates does not set.

Signature: **Date:**

Aboite Podiatry Associates, PC - Privacy Notice Acknowledgment

I acknowledge that I have received or been offered the Notice of Privacy Practices of Aboite Podiatry Associates. I understand that the notice describes the uses and disclosures of my protected health information and informs me of my rights with respect to this information. I understand if I have any questions, I may contact the office at 260-436-3579 for clarification.

Patient Name Printed: _____

Patient Signature: _____ **Date:** _____

Authorized Signature
(if other than patient): _____ Relationship: _____

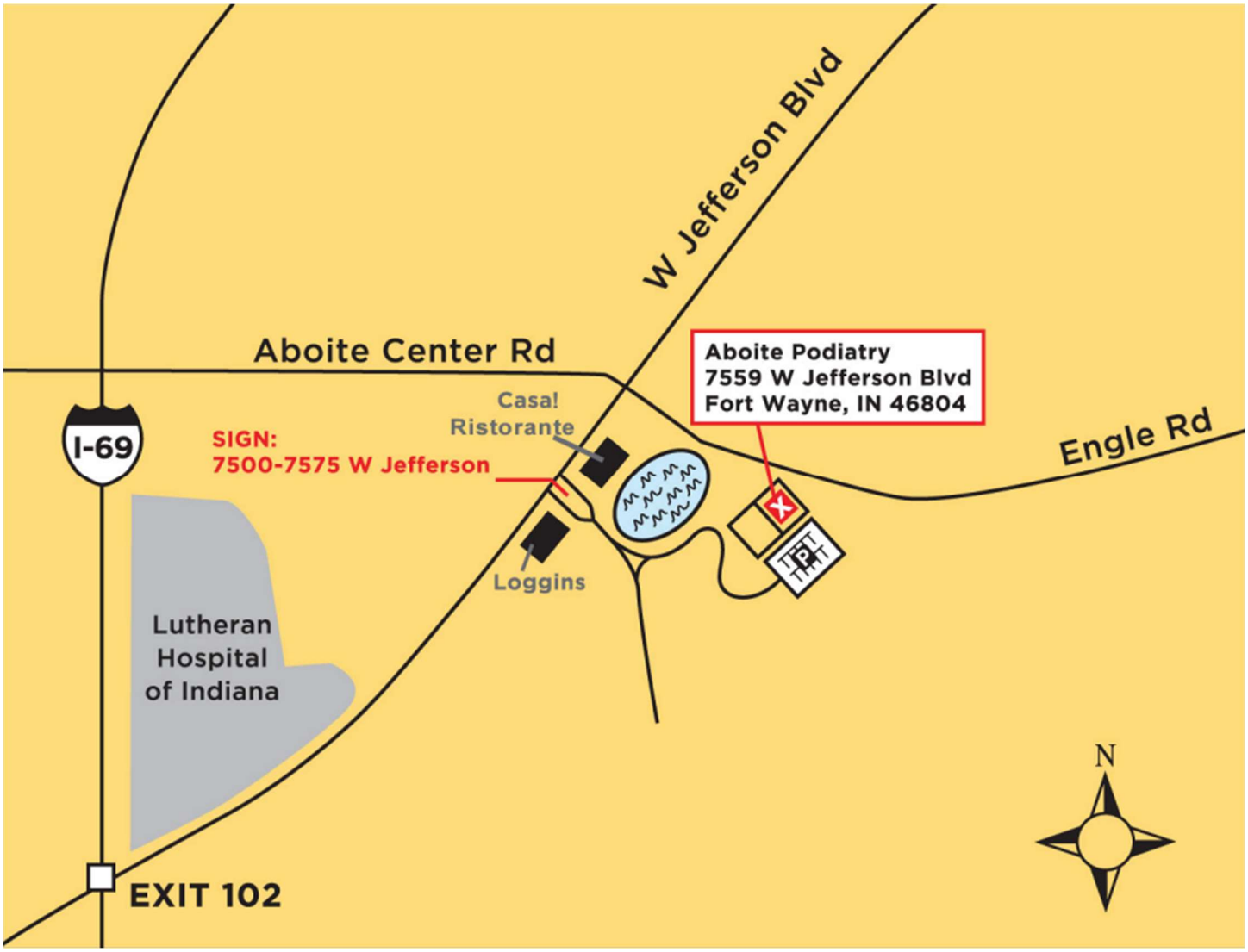
HIPAA FAMILY & FRIENDS AUTHORIZATION

Please list those persons you authorize Aboite Podiatry Associates to release PHI information to:

Name	Phone Number	Relationship

* If you do not want to list anyone, please write 'NONE' and sign below.

Signature: _____ **Date:** _____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