



**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?	<input type="checkbox"/> Yes, ( ) number of packs per day	<input type="checkbox"/> No
Do you drink alcohol?	<input type="checkbox"/> Yes, (list # drinks/frequency)	<input type="checkbox"/> No
Do you take recreational drugs?	<input type="checkbox"/> Yes, (list types)	<input type="checkbox"/> No
Do you actively participate in sports?	<input type="checkbox"/> Yes, (list types)	<input type="checkbox"/> No
Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Physical History** (Check all that apply)

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

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

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

Other/Additional Info

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**Patient Name:**

**Date of Birth:**

**Present Medical Conditions** (list)

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**Family History** (Check all that apply)

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|---|--|
| <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Heart Disease       |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cancer         | <input type="checkbox"/> Kidney Disease      |
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Liver Disease       |
| <input type="checkbox"/> Foot Disorder  | <input type="checkbox"/> Other (specify)     |

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

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- |  |                                     |                             |
|--|-------------------------------------|-----------------------------|
| Do you have any pins, screws, plates, or implants? | <input type="checkbox"/> Yes (list) | <input type="checkbox"/> No |
| Do you have any joint replacements?                | <input type="checkbox"/> Yes (list) | <input type="checkbox"/> No |
| Do you have a pacemaker?                           | <input type="checkbox"/> Yes (list) | <input type="checkbox"/> No |

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

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**Present Medications**

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

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**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:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address:		
City:	State:	Zip code:
Primary Phone:	Secondary Phone:	
Email address: <i>(required to access the patient portal)</i>		
Statement Preference: <input type="checkbox"/> Email <input type="checkbox"/> Text <input type="checkbox"/> Paper Only		
Preferred Language:	Ethnicity:	Race:
Occupation:	Employer Name:	

**Marital Information**

Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Separated	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> 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:**

tjm 12-4-23

**Date:**

**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:**

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I hereby give Dr. Matthew Robison, Dr. Jacqueline Monroe, Dr. William Arthur, Dr. Ashley M. Bojrab 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:**

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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:**

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**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:** \_\_\_\_\_

