SOWELL PODIATRY
.COM

PATIENT DATA/EMERGENCY NUMBERS

Date:____/____/____

STAFF USE

Name:_____ Your Occupation

Acct#_____

Shoe Size_____ Weight_____ Height_____

Reviewed:_____

☐ NEW ☐ UPDATE

In case of emergenvy, please firts call:

Phone -Day _____

Phone -Evening _____

Friend or Relative not living with you:

Phone -Day _____

Phone -Evening _____

Please provide your preferred Pharmacy:

Street/ City: _____

Phone: _____

PATIENT MEDICAL HISTORY

Do you have or ever been treated for:

☐ Epilepsy	☐ Nerve disorder	☐ Cancer
☐ Depression	☐ Stomach Ulcer	☐ Psychiatric Disorder
☐ Glaucoma	☐ Rheumatic Fever	☐ Scarlet Fever
☐ Stroke	☐ Heart Attack	☐ High Blood Pressure
☐ Trauma	☐ Phlebitis	☐ Heart Disease
☐ Diabetes	☐ Hepatitis	☐ Liver Disease
☐ Anemia	☐ Gout	☐ Kidney Disease
☐ Asthma	☐ Lung Disease	☐ None of these

Additional **NOT LISTED** above:

Are you currently taking any medication ☐ Yes ☐ No

Medication For what reason? How long

Allergies: Do you have a history of skin reaction or oher outward reaction or sickness following an injection, oral or topical administration of.

(check box that applies)	*Yes*	*No*	*Don't know*
Penicillin or other antibiotics	☐	☐	☐
if yes, what happens: _____			
Morphine, Codeine Denerol or other narcotic	☐	☐	☐
if yes, what happens: _____			
Novocaine or other anesthetics	☐	☐	☐
if yes, what happens: _____			
Aspirin, Empirin or other pain remedies	☐	☐	☐
if yes, what happens: _____			
Sulfa drugs	☐	☐	☐
if yes, what happens: _____			
Adhesive tape	☐	☐	☐
if yes, what happens: _____			
Shrimp, Iodine or Merthiolate	☐	☐	☐
if yes, what happens: _____			
Any other medication or treatment	☐	☐	☐
if yes, List _____			

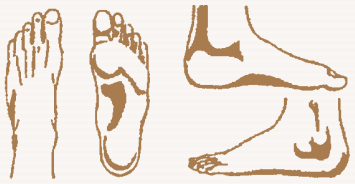
Do you smoke now? ☐ No ☐ Yes Packs/day _____ Years _____

Did you ever smoke? ☐ No ☐ Yes Packs/day _____ Years _____

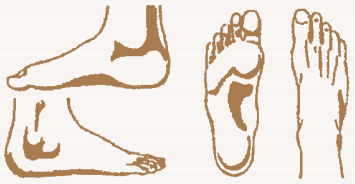
PATIENT CURRENT MEDICAL PROBLEMS

Describe up to 2 main problems in greater detail below & mark on the diagram below the areas where you have each problem using numbers 1 to 2 to identify.

LEFT FOOT



RIGHT FOOT



1. Please mark the location of your first problem or pain on the diagrams above with a number 1. Describe your problem below and it's cause if you know. Please describe associated pain.

My first problem is... ☐ On Left foot ☐ On Right foot ☐ On Both feet

_____ Is this problem work related? ☐ Yes ☐ No

Date of injury:_____ Date of report to employer:_____

My Pain/Discomfort began:_____

It occurs when:_____

Previous medical treatment(s) or home remedies:

2. Please mark the location of your first problem or pain on the diagrams above with a number 2. Describe your problem below and it's cause if you know. Please describe associated pain.

My first problem is... ☐ On Left foot ☐ On Right foot ☐ On Both feet

_____ Is this problem work related? ☐ Yes ☐ No

Date of injury:_____ Date of report to employer:_____

My Pain/Discomfort began:_____

It occurs when:_____

Previous medical treatment(s) or home remedies:

Additional Information: _____

Patient Family Physician Referred by ☐ Yes ☐ No

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Carthage Office • 305 West Cottage • Carthage, TX 75633 • (903) 694-9521 • (877) 747-3668 Toll-free

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PATIENT INFORMATION

Thank you for choosing sowell podiatry! In order to serve you properly, we need the following information.
Please print. All information will be kept confidential.

Date _____ Patient Name _____ Home Phone _____

SS# _____ ☐ Male ☐ Female Birthdate _____

Address _____ City _____ State _____ Zip _____

Circle appropriate status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Seperated

Patient's or parent/guardian employer _____ Work Phone _____

Bisiness Address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work Phone _____

If patient is a student, name of school/college _____ City _____ State _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone _____

In case of an emergency, if the patient is of school age 15+, it is all right to treat in my absence.

X _____ _____
Parent or guardian signature Date

Responsible Party

Name of person responsible for this account _____ Relationship _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Employer _____

Work Phone _____ Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of insured _____ Relationship _____

Birthdate _____ SS# _____ Work Phone _____

Name of employer _____ Date employed _____

Addresse of employer _____ City _____ State _____ Zip _____

Insurance of employer _____ Group # _____ Deductible amount _____

Do you have additional insurance? ☐ Yes ☐ No If yes. complete the following:

Name of insured _____ Relationship to patient _____

Birthdate _____ SS# _____ Work Phone _____

Name of employer _____ Date employed _____

Address of employer _____ City _____ State _____ Zip _____

Insurance company _____ Group# _____ Deductible amount _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating & administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____ Date _____
Signature of patient or parent / guardian if minor Date

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MODEL PATIENT ACKNOWLEDGMENT OF RECEIPT
SOWELL PODIATRY NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge receiving a copy of Sowell Podiatry Notice of Privacy Practices, dated _____

Patient Name _____ Patient D.O.B. _____

Patients Social Security # _____

X _____ _____
Signature of patient or personal representative* Date

* If signed by a Personal Representative, the following information must also be included:

Name of Personal Representative _____

Description of the Personal Representative's authority to act on behalf of the patient

_____

_____

_____

_____

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