

# WELCOME

Thank you for selecting Mitchell J Wachtel, DPM! Dr. Wachtel and Staff will strive to provide you with the best Podiatric care. To help us meet this goal, please fill out this form. If you need any assistance, please ask us – we will be happy to help!

## PERSONAL INFORMATION

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Street: \_\_\_\_\_ City/Town: \_\_\_\_\_ Zip \_\_\_\_\_

Birth date: \_\_\_\_\_ SS# \_\_\_\_\_ Sex: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Whom may we thank for your referral: \_\_\_\_\_  
Phone Book      Newspaper      Office Sign      other \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Pharmacy of Choice: \_\_\_\_\_ Telephone: \_\_\_\_\_

Patients Shoe Size: \_\_\_\_\_ Weight: \_\_\_\_\_

## RESPONSIBLE PARTY

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Birth Date: \_\_\_\_\_ SS# \_\_\_\_\_

## PRIMARY INSURANCE COMPANY

Please provide insurance card

Insurance Company Name: \_\_\_\_\_

## SECONDARY INSURANCE COMPANY

Please provide insurance card

Insurance Company Name: \_\_\_\_\_

I authorize Dr Wachtel and Associates to treat me for my Foot and Ankle problems. I also authorize the Doctor to release any information including the Diagnosis and the records of this treatment to any third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor's group insurance benefits otherwise payable to me. I understand the insurance company may pay only a percent of the total bill. I accept responsibility for my balance. If my bill does become delinquent and requires collection, all cost of collection will be added to my outstanding balance. I understand that if payment for services is denied for any reason by my insurance company that I am fully responsible for payment. In the event that this account not paid, I understand that I will be responsible for reasonable attorney fees and costs of collection. I acknowledge that I have received Notice of Privacy Practices which are in compliance with HIPAA.

Patient/Guardian

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **PODIATRIC HISTORY and PHYSICAL**

### **About your Problem**

What is the location of your foot or ankle problem? \_\_\_\_\_

\_\_\_\_\_

What type of pain are you having? \_\_\_\_ Sharp \_\_\_\_ Dull \_\_\_\_ Throbbing

Describe the nature of the pain \_\_\_\_ New Onset \_\_\_\_ Constant \_\_\_\_ Intermittent

Explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever had treatment before: if yes, where? \_\_\_\_\_

What type of treatment was completed for your problem? \_\_\_\_\_

\_\_\_\_\_

## About your Medical History

<p><b>MAJOR DISEASE</b></p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Angina</p> <p><input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> Arrhythmia</p> <p><input type="checkbox"/> Murmur</p> <p><input type="checkbox"/> Mitral Valve Prolapse</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Chest Pain</p> <p><b>HEENT:</b></p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Eye Problems</p> <p><input type="checkbox"/> Hearing Problems</p> <p><b>RESPIRATORY</b></p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Frequent colds</p> <p><input type="checkbox"/> Lung Disease</p> <p><input type="checkbox"/> Short of breath</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Emphysema</p>	<p><b>ARTHRITIS</b></p> <p><input type="checkbox"/> Osteoarthritis</p> <p><input type="checkbox"/> Rheumatoid</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Sero-negative</p> <p><b>VASCULAR</b></p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Sickle Cell</p> <p><input type="checkbox"/> Bleeding Disorders</p> <p><input type="checkbox"/> Poor Circulation</p> <p><input type="checkbox"/> Night Cramps</p> <p><input type="checkbox"/> Leg pain when walking</p> <p><input type="checkbox"/> Vein Problems</p> <p><input type="checkbox"/> Spider Veins</p> <p><input type="checkbox"/> Varicose Veins</p> <p><input type="checkbox"/> Swelling/Phlebitis</p> <p><input type="checkbox"/> Leg Ulcerations</p> <p><input type="checkbox"/> Blood Clots</p> <p><input type="checkbox"/> Transfusions</p> <p><b>GASTROINTESTINAL</b></p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Stomach Prob</p> <p><input type="checkbox"/> Hiatal Hernia</p>	<p><b>MISCELLANEOUS</b></p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Thyroid Disease</p> <p><input type="checkbox"/> Muscle Disease</p> <p><input type="checkbox"/> Kidney Problems</p> <p><input type="checkbox"/> Bladder Problem</p> <p><input type="checkbox"/> Prostate Problem</p> <p><input type="checkbox"/> Venereal Disease</p> <p><input type="checkbox"/> Skin Conditions</p> <p><input type="checkbox"/> Cancer History</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Hysterectomy</p> <p><input type="checkbox"/> HIV</p> <p><b>PSYCHOLOGICAL</b></p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Psychiatric Cond.</p> <p><input type="checkbox"/> Drug dependence</p> <p><input type="checkbox"/> Alcohol Abuse</p> <p><b>OTHER ILLNESS</b></p> <p>_____</p> <p>_____</p>
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Current Medications:	Current Allergies:

Dr. Wachtel will make every effort to explain your diagnosis and treatment option to you. If for any reason you do not understand something, please stop the doctor. Ask all the questions you need to feel comfortable. Dr. Wachtel is here for you.

RELEASE OF PRIVATE HEALTH INFORMATION

**TO. MITCHELL J WACHTEL, DPM**

To insure proper and timely handling of your medical information, please provide us with the following information:

Home Telephone Number	
Work Telephone Number	
Day Phone Number	
Alternate Phone Number	

I authorize the above named physician or one of his associates employed by his practice to release any and all medical test results or other medical private health information relating to my treatment to:

Please initial your choices that are acceptable to you. If you do not want an option, please leave it blank to indicate we do not have your permission to use that choice.

- May leave message at work to call the office
- May leave a message on answering machine/voice mail to call office
- May leave a message with a family member to call the office
- May leave test results on answering machine/voice mail
- May give test results to designated person:  
Name: \_\_\_\_\_ Relationship \_\_\_\_\_
- May release test results only to myself.

I understand this Release will be in effect unless changed or revoked by myself either in writing or by completing a new release.

Date	
Patient Name	
Address	
Social Security #	
Date of Birth	

Signature: \_\_\_\_\_ Witness: \_\_\_\_\_