

Smita Malhotra, DPM
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Patient Information:

Name: _____
Social Security #: ____-____-_____
Address: _____
City: _____ State: _____ Zip Code: _____
Email: _____ Sex: () Male () Female
Age: _____ Date of Birth: _____
() married () single () widowed () other _____
Employer/School _____
Employer/School Address _____

Employer/School Phone _____
Spouse's Name _____
Spouse's Employer _____
Whom may we thank for referring you? _____

Phone Numbers

Home() _____ Cell phone () _____
Best time and place to reach you _____
In case of emergency, contact:
Name _____ Relationship _____
Home phone _____ Work phone _____

Insurance Information

Who is responsible for this account? _____
Relationship to patient _____
Primary Insurance Co _____ Group# _____
Secondary Insurance(if any) _____ Group# _____
Subscriber's Name _____ Birthdate _____
Relationship to Patient _____

I authorize Dr. Malhotra to diagnose, treat and evaluate my medical condition. I understand that I am financially responsible for all charges whether or not paid for by my insurance. Dr. Malhotra may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits for related services.

Signature of Patient/Guardian/Personal representative

Print Name

Relationship to Patient

Date

Podiatric History

What is the primary foot problem for which you came to be treated?

Have you ever been to a podiatrist before? Yes () No ()

If yes, please list Name _____ Last visit _____

Reason for visit _____

Is there any personal or family history of diabetes? ___yes ___no

Other significant family history? _____

Your occupation _____

Do you drink? ___yes ___no

If yes, how many drinks per day? _____

Cigarette/Tobacco use per day _____ Years smoked _____

Recreational Drug Use? _____

Athletic Activities in which you participate in: _____

Please indicate which foot problems you now have or have had in the past:

Ankle pain: _____ yes _____ no

Athlete's foot: _____ yes _____ no

Bunions: _____ yes _____ no

Cramps feet/legs: _____ yes _____ no

Numbness feet/legs: _____ yes _____ no

Flat feet: _____ yes _____ no

Heel pain : _____ yes _____ no

Ingrown nails: _____ yes _____ no

Warts: _____ yes _____ no

Swelling: _____ yes _____ no

Discolored nails: _____ yes _____ no

Foot infections: _____ yes _____ no

Amputations: _____ yes _____ no

Other: _____

Medical History:

Have you ever had or ever been treated for the following (either now or in the past)?

Yes

- AIDS/HIV
- Allergies to anesthetic
- Allergies to medicine
- Anemia
- Angina
- Artificial valve or joint placement
- Asthma
- Back problems
- Bleeding disorders
- Blood clots
- Cancer
- Chemical dependency
- Chest pain
- Chronic diarrhea
- Circulatory problems
- Diabetes
- Ear problems
- Epilepsy
- Eye problems
- Fainting
- Foot or leg cramps
- Gout
- Headaches
- Heart attacks
- Heart disease
- Heart murmur
- Hemophilia
- Hepatitis or jaundice
- High blood pressure
- Kidney problems
- Liver disease
- Low blood pressure
- Neuropathy
- Phlebitis
- Psychiatric care
- Radiation treatment
- Rash
- Reflux disease
- Respiratory disease
- Rheumatic fever
- Shortness of breath
- Sinus problems
- Special diet
- Stroke
- Swelling swollen neck glands
- Tuberculosis
- Foot Ulcers
- Stomach ulcers
- Varicose veins

Venereal disease
 Unexplained weight loss

Surgeries you have had: _____

Hospitalizations other than for surgeries: _____

Family doctor _____ Last seen _____
Are you now or have been under the care of any other doctor for any
reason over the past two years? yes no. If yes, please
explain _____

Medications you are currently on:

Pharmacy Name and phone number _____

Do you take oral contraceptives? yes no

Do you need to take antibiotics before going to see a dentist or before
any procedure? yes no

Allergies to any of the following:

<input type="checkbox"/> tape	<input type="checkbox"/> local anesthetic	<input type="checkbox"/> Anticoagulant therapy
<input type="checkbox"/> aspirin	<input type="checkbox"/> novocaine	<input type="checkbox"/> penicillin
<input type="checkbox"/> sulfa	<input type="checkbox"/> seafood	<input type="checkbox"/> iodine
<input type="checkbox"/> codeine	<input type="checkbox"/> Demerol	<input type="checkbox"/> triple antibiotic ointment

OTHER: _____

**Is there anything else you want us to know about you that might aid us
in providing you better care?** _____

Treatment consent:

I hereby consent and give my permission to the doctor and the doctor's
assistants or designated replacement to administer and perform such
procedures upon me as the doctor deems necessary.

Signature of patient/guardian

Date

Please print name