

CHRISTOPHER P. FARNWORTH, D.P.M., MICHAEL J. FRANK, D.P.M., MARC GOLDBERG, D.P.M.

10801 Lockwood Drive, Suite 260
Silver Spring, Maryland 20901
(301) 439-0300

3408 Olandwood Ct. Suite 204
Olney, Maryland 20832
(301) 924-5044

7900 Old Branch Ave., #110
Clinton, Maryland 20735
(301) 868-7670

PATIENT INFORMATION

Date _____
SS/HIC/Patient ID # _____
Patient Name _____
Last Name _____
First Name _____ Middle Initial _____
Address _____
City _____
State _____ Zip _____
E-mail _____
Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
Patient Employer/School _____
Employer/School Address _____
Employer/School Phone (_____) _____
Spouse's Name _____
Birthdate _____ SS# _____
Spouse's Employer _____
Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? Yes No
Subscriber's Name _____
Birthdate _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to Drs. Christopher Farnworth, Michael Frank, and Marc Goldberg, all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I authorize the use of my signature on all insurance submissions.
The above-named doctor 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 plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Drs. Farnworth, Frank, and Goldberg for any services furnished to me by that provider.
To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

PHONE NUMBERS

Home Phone (_____) _____
Cell Phone (_____) _____
Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____
Relationship _____
Home Phone (_____) _____
Work Phone (_____) _____

Signature of Beneficiary, Guardian or Personal Representative

Please print name of Beneficiary, Guardian or Personal Representative

Date _____ Relationship to Beneficiary _____

PODIATRIC HISTORY

What is the chief complaint of which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

Is there any personal or family history of diabetes?
 Yes No
Your occupation _____
Cigarette/Tobacco use _____
Years smoked _____

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

Have you ever been to a Podiatrist before?
 Yes No
If yes, please list.
Name _____
Last visit _____

Athletic activities in which you participate (please list and indicate frequency)

- Ankle Pain Yes No
- Athlete's Foot Yes No
- Bunions Yes No
- Corns and Calluses Yes No
- Cramps or Numbness in Feet or Legs Yes No
- Flat Feet Yes No
- Foot or Leg Cramps Yes No
- Heel Pain Yes No
- Ingrown Toenails Yes No
- Plantar Warts Yes No
- Swelling in Ankles or Feet Yes No
- Tired Feet Yes No

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | |
|-----------------------------------|--|-----------------------|--|--------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Anesthetics | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Medicine or Drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Foot or Leg Cramps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves or Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling in Ankles, Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis or Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tired Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Varicose Veins | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chronic Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neuropathy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Phlebitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Ear Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Surgeries you have had _____

Hospitalization other than for the surgeries listed _____

Family physician _____ Last visit date _____
 Are you now, or have you been, under any other doctor's care for any reason over the past two years? Yes No

If yes, please explain _____

MEDICATIONS	ALLERGIES												
Include prescriptions, over-the-counter medications and vitamins _____ _____ _____ Pharmacy Name(s) _____ Pharmacy Phone(s) _____ Do you take oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No	<table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Adhesive/Tape</td> <td><input type="checkbox"/> Ibuprofen</td> </tr> <tr> <td><input type="checkbox"/> Anticoagulant Therapy</td> <td><input type="checkbox"/> Local Anesthetics</td> </tr> <tr> <td><input type="checkbox"/> Aspirin</td> <td><input type="checkbox"/> Penicillin</td> </tr> <tr> <td><input type="checkbox"/> Codeine</td> <td><input type="checkbox"/> Sea Foods</td> </tr> <tr> <td><input type="checkbox"/> Demerol</td> <td><input type="checkbox"/> Sulfa Drugs</td> </tr> <tr> <td><input type="checkbox"/> Iodine</td> <td><input type="checkbox"/> Latex</td> </tr> </table> Other _____	<input type="checkbox"/> Adhesive/Tape	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Anticoagulant Therapy	<input type="checkbox"/> Local Anesthetics	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Sea Foods	<input type="checkbox"/> Demerol	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Iodine	<input type="checkbox"/> Latex
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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, Parent, Guardian or Personal Representative

 Date

 Please print name of Patient, Parent, Guardian or Personal Representative

 Relationship to Patient

Drs. Farnworth, Frank, and Goldberg reserve the right to bill new and established patients for missed appointments and appointments canceled without 24 hours notice.