WELCOME to Dr. Levesque's office. So that we may serve you to the best of our ability, please complete both pages as accurately as possible and return to the receptionist with your insurance card.

Patient's
Last Name: _____ First Name: _____ MI: ____

☐ Mr. ☐ Mrs. ☐ Female
☐ Ms. ☐ Other _____ ☐ Male

Home Phone (____) _____
Cell Phone (____) _____
Work Phone (____) _____

Zip Code: _____
Street :_____ Town: _____

Birthdate _____ / _____ / _____ Age: _____ Employment ☐ Employed ☐ None/Retired
Marital Status ☐ Married ☐ Single Status ☐ Full-time student
☐ Widowed ☐ Other ☐ Part-time Student
Employer _____ Occupation _____

- Race (circle): Caucasian Hispanic African American Indian East Asian American Indian Other: _____
- Ethnicity (circle): Hispanic or Latino Not Hispanic or Latino Unknown Other: _____
- Nationality (circle): American Canadian Mexican Other: _____

If patient is a minor or under someone else's care please fill in below
Responsible Billing Party _____
Full Address _____
Home Phone (_____) _____ Work Phone (_____) _____
Relationship to patient: ☐Child ☐Parent ☐Guardian ☐Sibling ☐Other

Who Referred you? ☐Doctor ☐Patient ☐Insurance ☐Athletic Trainer ☐Coach ☐Internet ☐ Other
Name: _____ Address: _____

PODIATRIC HISTORY

Chief foot/ankle complaint (be specific, include area of foot: heel, ball, arch, toe, nails, etc. also include any knee, thigh, hip, and lower back complaints)
_____
_____
_____
_____
_____

Have you been treated by a podiatrist before? _____
Name:_____

Last Visit _____

Do you have/wear orthotics_____

Current exercise/athletic activities (list all and note frequency)
_____
_____
_____
_____

Height _____
Weight _____
Blood Pressure _____
Shoe Size _____

☐ Smoker ☐ Non-Smoker
☐ Former Smoker
☐ Chewing Tobacco

Alcohol: ☐ None ☐ Socially
☐ 2+ drinks per day

Check any current or past foot related problems:
☐ Heel Pain
☐ Ankle Pain
☐ Arch Pain
☐ Flat Feet
☐ Low Back Pain
☐ Shin Pain
☐ Knee Pain
☐ Stress Fracture
☐ Cramps
☐ Bunion
☐ Swelling
☐ Tired Feet
☐ Numbness in feet and/or legs
☐ Ingrown Toenails
☐ Athlete's Foot/fungus
☐ Corns & Callus
☐ Plantar Warts

Have you had any of the following:

☐ ALS ☐Arteriosclerosis
☐ Arthritis ☐Back Problems
☐ Bleeding Disorders ☐Cancer
☐ Buerger's Disease ☐Stroke
☐ Congestive Heart Failure ☐Kidney Disease
☐ Diabetes ☐Type 1 ☐Type 2 ☐T.B.
☐ Lymphedema ☐Ulcers
☐ Heart Disease ☐Heart Attack
☐ Hemophilia ☐Venous Insufficiency
☐ High Blood Pressure ☐Nervousness
☐ Chemical Dependency ☐Gout
☐ Thrombophlebitis ☐ **None of the above**
☐ Numbness in feet and or legs
☐ Circulation problems of the feet and/or legs

☐ **I Have NO KNOWN <u>DRUG</u> Allergies**

Are you Allergic to any of the following:

☐ Novocain ☐Demerol ☐Shellfish
☐ Iodine ☐Athletic Tape ☐Latex
☐ Aspirin ☐Penicillin ☐Epinephrine
☐ Codeine ☐Sulfa ☐Local Anesthetics
☐ Any other Allergies? _____
_____
_____

Any medications that you can **<u>NOT</u>** take?

_____ _____
_____ _____

Primary Care Doctor:_____
Address _____
Phone # (_____) _____

In general, for what does this physician treat you?

_____
_____
_____

Date last seen _____
How often do you see this physician? _____

List all medications you are currently taking:

	Dosage

Your Pharmacy _____
Town: _____Zip Code: _____

INSURANCE INFORMATION

Medicare ID # _____

Secondary Insurance
Company Name: _____
ID # _____ Group # _____

Patient's relationship to policy holder: ☐ Self ☐ Spouse ☐ Dependent

Policy Holder's Name: _____
Birthdate ____ / ____ / _____
Address: _____
Employer _____

<u>Medicare does not cover Routine Foot Care</u>.
This may include cutting or removal of corns and calluses and trimming of toe nails. Routine Foot Care may be covered if you have an underlying medical problem severe enough to put you at risk if your foot care was not provided by a medical professional and you are under the frequent care of a medical doctor for your at risk condition. These conditions may include severely reduced circulation, lack of feeling in your feet, abnormal sensations in your feet, lack of pulses in your feet or amputation of toes.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby do authorize payment directly to Dr. Levesque. Since Dr. Levesque accepts assignment with Medicare I am responsible for any deductible and co-insurance amounts, as well as payment for all non-covered services rendered to me by Dr. Levesque.

X _____ Date: _____