hutt podiatry, inc.

Patient Information Sheet

Date: _____ Referred By: _____

Patient Name: _____ SSN#: _____ Birthdate: _____ Age: ____

Address: _____ City/State/Zip: _____

Phone Number: _____ Sex: M F Martial Status: M S W D

Cell Phone: _____ Email Address: _____

Patient Pharmacy: _____ Pharmacy Phone #: _____

Person Responsible for Bills(If other than Patient)

Name: (Last, First, MI) _____ DOB: _____

Telephone #: _____ Relation to Patient: _____

Address(if different than patient): _____ SSN#: _____

Employer Information

Name of Employer: _____ Telephone #: _____

Street Address: _____ City: _____ State: _____ Zip: _____

I hereby consent to Dr. Dennis M. Hutt, DPM or his qualified designee to administer podiatric care and to perform minor operative procedures and/or other appropriate studies as may be deemed necessary or advisable for diagnosis and treatment of this patient.

Signature of Patient: _____ Date: _____

Signature of Parent or Gaurdian(if patient under 18): _____

wellington square, suite 101, 1226 south main street, greensburg, pennsylvania, 15601
phone: 724-832-8000 fax: 724-834-3333 email: huttpodiatry@gmail.com

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PATIENT QUESTIONNAIRE

Name: _____ **SS#:** _____ **Age:** _____ **Date:** _____

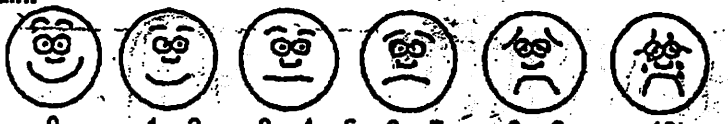
Who suggested that you see us? _____ **Primary Care MD:** _____

Why are you here today? _____

Injury: *Work Auto Other* _____

Date of Injury: _____

Pain:



Describe your pain *(sharp, ache, burn, tingling, tightness)*

Does the pain keep your from your Daily Activities? y / n

What makes your pain worse? _____

What makes your pain better? _____

Have you had? *(swelling, bruising, numbness, tingling)*

How may blocks can you walk? (0-1) (2-4) (4-6) (>7)

Have you changed your shoe wear? _____

Have you had Physical Therapy? y / n

Do you have difficulty with? *(uneven surfaces, stairs, inclines, ladders)*

HPI: *(for MD to fill out)* _____

Please circle all that apply

General
Fever
Chills
Night sweats
Weight loss
Weight gain
Fatigue

HEENT
Difficulty with vision
Hay fever
Recent cold
Dizziness
Trouble swallowing

Cardiovascular
High blood pressure
Heart failure
Chest pain or tightness
Irregular heart beat
Pace maker
Heart attack
Varicose veins
Hardening of the arteries
Phlebitis

GI
Ulcers
Abdominal pain
Nutritional problems
Acid reflux
Liver disease (Hepatitis, cirrhosis)

GU
Urinary tract infections
Prostate difficulties
Kidney damage
Blood in urine
Kidney stones
Dialysis
Pregnant
Menstrual problems
Last menstrual period

Endocrine
Diabetes
Thyroid disease

Rheumatologic
Arthritis
(osteoarthritis/rheumatoid)
Osteoporosis
Joint pain
Swelling
Stiffness

Infection
Recent cellulitis
Bone or joint

Neurological
Numbness
Tingling
Stroke
Mini-Stroke (TIA)
Tremors
Neuropathy

Hematologic
Bleeding disorder
History of cancer

Skin
Poor healing
Easy bruising
Leg wounds

Respiratory
Asthma
Bronchitis
Emphysema
Pneumonia
Short of breath
Cough
Blood clot (in lungs)

Psychological
Stress
Anxiety
Depression

List All Meds:

List ALL surgeries and hospitalizations: _____

Allergies: _____

Family History: ☐ Diabetes ☐ Neuropathy ☐ Malignant Hyperthermia ☐ Vascular Disease ☐ Rheumatoid Arthritis

Social History: ☐ Tobacco ☐ Alcohol ☐ Drugs

Occupation and Employer: _____

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INSURANCE AUTHORIZATION

SIGNATURE ON FILE

- ☐ I authorize the doctor named above to use my name on **any and all** claims or documents that relate to health insurance benefits due to me and my dependents.
- ☐ I authorize release of any information related to any claims to all my **Insurance Companies** or other relevant parties.
- ☐ I understand that **I am responsible** for my bill and agree to pay all charges for services and items provided to me.
- ☐ I authorize my doctor to act as **my agent** in helping me obtain payment from my Insurance companies.
- ☐ I authorize payment of health benefits otherwise payable to me, directly to my doctor.
- ☐ I permit a copy of this authorization to be used in place of the original.
- ☐ The "Signature on File" is **valid for one year** from the date indicated below.

_____ _____

Signature of Beneficiary, Guardian, or Personal Representative Date

_____ _____

Please print name of Beneficiary, Guardian, or Personal Representative Relationship to Beneficiary

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ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

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