South Side Foot & Ankle
Dr. Julie Wieger DPM
3506 South Michigan St.
South Bend, IN 46614
Phone: 574/231-1960
Fax: 574/231-1961

NEW PATIENT INTAKE FORM

Name:______________________________ Gender ____M____F

Date of Birth:______________ Age__________ Social Security #:______________

Address: ______________ City:______________ State:____ Zip________

Home Phone #:__________ Work Phone#:__________ Cell Phone:__________

Marital Status: ____ Single ____Married ____Divorced ____ Widowed ____ Partner ____Legally Separated

Emergency Contact: ______________ Phone:__________ Cell Phone:__________

E-Mail Address :______________ Primary Spoken Language ______________

Employment Status ___Full-Time ___Part-Time ___Not Employed

Student Status ____ Full-Time ___Part-Time ___Not a Student

Race:
American Indian or Alaska Native ____ Native Hawaiian or other Pacific Islander ____
Black or African American ______ Asian ____ White ____

Ethnicity:
Hispanic or Latino ______ Not Hispanic or Latino______

Primary Care Physician:______________ Referred by:______________

Cardiologist:______________ Endocrinologist:______________

Nephrologist:______________ Rheumatologist:______________

Please describe your foot/ankle problem (include date of injury if applicable)

____

____

____

How long has the problem been present?______________________________

Have you had any treatment or taken anything for it?______________________________

Have you seen someone for this already? __No __Yes Whom?______________

Have you had any prior foot/ankle problems? If yes, please describe: ___No Yes______________

____

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SURGICAL HISTORY

Surgical Procedures/Serious Injuries/Illnesses	Year	Physician	Hospital

Has any **family member** had any of the following (please indicate relationship)

Cancer: ____________________ Diabetes: ____________________

Heart Trouble: ____________________ High Blood Pressure: ____________________

Kidney Disease: ____________________ Mental or Emotional Disease: ____________________

Stroke: ____________________ Tuberculosis: ____________________

Arthritis: ____________________ Emphysema: ____________________

Blood clots: ____________________ Other:

PATIENT INFORMATION

Do you smoke currently? ____Yes ____No How many packs per day? ________ For how many years? _____

Have you smoked previously? ___Yes ___No When did you quit? _____

Number of caffeine drinks per day? _____ Amount of alcohol consumed per week _____

For women only: Are you pregnant? _____ How many months? _____

Please complete the following:

Height: ______ Weight: ______ Shoe size: ______ Occupation: ____________________

Is there any other information you would like us to be aware of: _____No ___Yes

Please describe: ____

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ALLERGIES

Please check all allergies:

____ Medications:______________________________

____ Foods:______________________________

____ Tapes or Topical Skin Sensitivity____ Other:______________________________

What types of reactions have you experienced?

____

____

MEDICATIONS

Please list all medications and the dosages:

1.______________________ 6.______________________

2.______________________ 7.______________________

3.______________________ 8.______________________

4.______________________ 9.______________________

5.______________________ 10.______________________

Personal Medical History:

****Check those that apply to you now or have applied to you in the past****

	Frequent Headache/Migraines		Anemia/Blood Disorders
	Liver Disorder		Pneumonia
	Kidney Disease		Drug/Alcohol Abuse
	Dialysis M W F or T TH SA		Epilepsy or Seizures
	Diabetes Average Blood Sugar ______		Prolonged Bleeding Time
	Asthma		Stomach/Ulcer Disorder
	Emphysema		Thyroid/Parathyroid Disease
	Heart Trouble		High Blood Pressure
	Stroke		Arthritis
	Chest Pain on Mild Exertion		Psychiatric Treatment
	Gout		Emotional Problems/Tension
	BLOOD CLOTS		Asthma/Hay Fever/Shortness of Breath
	Tumor/Abnormal Growth/Cancer		Sexually Transmitted Disease
	Ear, Nose, Throat Disorder		Prostate Disorder
	Hepatitis/HIV		Other

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Review of Systems

Please circle off all that *currently* apply to you

MEDICAL CONDITIONS:

Diabetes High Blood Pressure Heart Disease Heart Murmur Heart Valve Seizures

Asthma Rheumatic Fever Hepatitis Strokè Gout Stomach Ulcers

Anemia Liver Disease Circulation Cancer Infections Nerve Problems

Thyroid Kidney Disease Bleeding Scarring Tuberculosis HIV

Hormones Arthritis Chills Seizures Fever

Muscular/ Skeletal: back pain joint pain joint redness joint swelling leg cramps morning stiffness
muscle tenderness neck pain stiffness weakness of muscles difficulty with walking

Neurological: burning in feet tingling in feet or toes numbness tremors

Psychiatric: addictions attempted suicide depression memory loss panic attacks

I hereby authorize direct payment of surgical and medical benefits on my behalf to the provider of these services that I would otherwise be payable to me if I did not make this assignment. I understand that I am personally responsible to the physician for charges not covered by my insurance agreement. I also understand that if my account becomes delinquent, I will be responsible for any costs of collection of my account, including collection fees and attorney costs. A $5.00 per month re-invoicing fee may apply to all accounts 60 days past due. I permit a copy of this assignment to be used in place of the original for purposes of billing.

The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital generated. Also, I herby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition, to use x-ray examination, or photographs as necessary.

I give Dr. Julie Wieger, D.P.M., permission to obtain and release medical information to insurance Companies and referring physicians. I have read the following and understand and agree to Dr. Julie Wieger DPM's office policy.

DATE ____________ SIGNATURE OF PATIENT OR LEGAL GUARDIAN ____________

**If not patient, relationship to patient:
___Parent ___Power of attorney ___Legal Guardian ___ Other:___________

Julie A. Wieger, DPM, FACFAS 3506 S Michigan St South Bend, IN 46614

AUTHORIZATION FOR RELEASE OF INFORMATION

Today's Date: ____________

Patient Name: ______________________________ Date of Birth____________

I hereby authorize South Side Foot & Ankle Clinic and its staff to disclose my individually identifiable health information to my insurance company and any requesting physicians' offices, hospitals, labs or testing facilities who may need this information to better assist in the billing process and in my medical care. (Exceptions to be listed below.)

In addition to the above stated, I also authorize personal and medical information to be released to: (Example: Spouse, Child, Parent, Etc.)

______________________________ Relationship: ____________

______________________________ Relationship: ____________

I DO NOT want the following person(s) or organization(s) to have access to my personal information:

____

____

______________________________ Date: ____________

Signature of Patient or patient's representative
(Form MUST be completed before signing)

Printed name of patient's representative (if applicable): ____________

Relationship to the patient (if applicable): ____________

****YOU MAY REFUSE TO SIGN THIS AUTHORIZATION****