Southern Oklahoma Podiatry Services, P.L.L.C.
Dr. Lloyd B. Landis & Dr. Franklin D. Cooper
2002 12th Avenue N.W. Suite F
Ardmore, OK 73401
580-223-0718 580-223-0719 (fax)

PATIENT INFORMATION

Name: ______________________________________ Date of Birth: ______________ Age: ______
(Last) (First) (Middle Initial)

Address: ______________________________________ SS#: ____________________ ☐ Male ☐ Female

City: ____________________ State: ______ Zip: __________ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: ____________________

E-mail: ______________________________ (*May we notify you by email for appointment reminder? ☐ YES ☐ NO)

☐ Student ☐ Full Time ☐ Part Time ☐ Employed ☐ Unemployed ☐ Retired

Employer: ____________________________ Address: ____________________________

Spouse Name: ____________________________ Phone: ____________________________

Race: ☐American Indian ☐African American ☐Hispanic ☐Native Hawaiian ☐ White ☐Unknown ☐Other

Ethnicity : ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Are you currently living in a : ☐ Long-Term Facility ☐ Skilled Nursing Facility ☐ Hospice (Specify name) ____________________

EMERGENCY CONTACTS

Emergency Contact: ____________________________ Relationship: ______________ Phone: ______________

Can this person receive information regarding your condition? ☐ Yes ☐ No

Emergency Contact: ____________________________ Relationship: ______________ Phone: ______________

Can this person receive information regarding your condition? ☐ Yes ☐ No

INSURANCE POLICY HOLDER INFORMATION

PRIMARY COMPANY: ____________________________

Address: ____________________________

City, State: ____________________ Zip: __________

ID#: ______________ Group#: ______________

Subscribers Name: ____________________________

Date of Birth: ______________ SS#: ______________

Address: ____________________________

City, State: ____________________ Zip: __________

Employer: ____________________________

SECONDARY COMPANY: ____________________________

Address: ____________________________

City, State: ____________________ Zip: __________

ID#: ______________ Group#: ______________

Subscribers Name: ____________________________

Date of Birth: ______________ SS#: ______________

Address: ____________________________

City, State: ____________________ Zip: __________

Employer: ____________________________

RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

Responsible Party: ____________________________ Responsible Party Date of Birth: ______________

Address: ____

Relationship to patient: ____________________ SS#: ______________ Home Phone: ______________

Responsible Party Employer: ____________________________ Work Phone: ______________

I request that payment of authorized benefits be made to **Southern Oklahoma Podiatry Services, P.L.L.C. or it's physicians** on my behalf for any services provided to me or my dependents. I authorize the release of any medical information to any insurance company, any third party payer, state agency, employer, or any other governmental or private payer responsible for paying such benefits. I agree to pay for all charges not covered by a third party payer. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for services rendered without obtaining my signature on each and every claim to be submitted for myself or my dependents. I authorize a copy of this document to be used in place of the original.

Signature of Patient/Insured: ____________________________________ Date: ______________

Date:______________________________ Acct #:__________________

MEDICAL INFORMATION

Name:________________________________ Date of Birth:____________________________ Age:____________________

Describe your foot or ankle pain:____

____

When did this condition begin:____

How did this condition begin:____

Did you bring xrays/MRI/CT:__________________________________ From Where:______________________

Is this condition related to: □ On the job injury □ Auto Accident □ Old Symptom □ Other

Have you been treated for this condition by another physician:______________________________________

Physician Name:___________________________________ Dates treated:___________________________

Please list any past problems or injuries with your feet or ankles:_______________________________

____

Primary Physician:________________________________ Phone:_____________________________

Cardiologist:_____________________________________ Pulmonologist:_______________________

Pharmacy Preferred:_______________________________ *Authorization to retrieve medication history from your pharmacy □Yes□No

Home Health:_____________________________________ Phone:_____________________________

PAST MEDICAL HISTORY

Have you ever had any of the following: (Please circle all that pertain to you)

Blood:
Anemia
Bleeding Disorders
Blood Clots
Cancer Type______________
Radiation Treatment
Hemophilia

Musculoskeletal:
Gout
Osteoarthritis
Rheumatoid Arthritis
Arthritis Other____________
Joint Stiffness
Joint Swelling
Leg Cramps
Joint Pain
Back Pain
Sciatica
Hip Pain
Knee Pain
Nighttime burning feet
Cramps of feet

Neurological:
Neuropathy- feet
Numbness feet/legs
Stroke
Paralysis
Seizures/Epilepsy
Migraine Headaches
Multiple Sclerosis
Cerebral Palsy
Nervous Disorder
Fainting

Peripheral Vascular:
Poor Circulation
Impotence
Calf Pain when Walking
Varicose Veins
Phlebitis
Swelling in the legs/feet

Psychology:
Depression/Anxiety
Sleep Disturbances
Psychiatric Care

Head:
Hearing Loss
Eye Problems
Macular Degeneration
Cataracts/Glaucoma

Endocrine:
Diabetes Type I / Type II
How Long?________yrs
Insulin Yes/ No
Hypoglycemia
Hyperthyroid
Hypothyroid
Osteoporosis
Special Diet

GI:
Intestinal disease
Stomach Ulcers
Reflux Disease/GERD
Chronic Diarrhea

Kidney:
Kidney Disease/Failure
Kidney Stones
Dialysis

Liver Disease:
Hepatitis A B C
Cirrhosis
Jaundice

Infectious:
AIDS/HIV
Tuberculosis
Lyme's Disease
Venereal Disease

Skin:
Rash
Keloid/Thick Scar
Psoriasis Type________
Changing Skin Lesion
Skin Cancer Type_________
Skin Ulcer Type___________

Respiratory:
Asthma
Bronchitis
Emphysema
Pneumonia
Pulmonary Embolism
Lung Problems
Shortness of Breath
Tuberculosis
Respiratory Disease

Cardiac:
Congestive Heart Failure
Heart Disease
High Blood Pressure
Low Blood Pressure
Previous Heart Attack
Date:______________
Irregular Beats
Murmur
Clogged Arteries (Stent)
Pacemaker
Chest Pain
Rheumatic Fever
Shortness of Breath
CPAP
EKG Where:___________
Date:______________

Weight loss
Chemical Dependency
Psychiatric Care
Artificial Joint Replacement
Type:______________

SHOE SIZE:____________

HEIGHT:______________

WEIGHT:______________

Date:______________________ Acct #:______________

MEDICATIONS

Are you currently taking contraceptives? ☐ YES ☐ NO Are you pregnant? ☐ YES ☐ NO Due Date:__________

Are you currently taking a blood thinner? ☐ YES ☐ NO How many per day?__________

Are you currently taking aspirin daily? ☐ YES ☐ NO How many per day?__________

PLEASE LIST ALL MEDICATIONS AND VITAMINS YOU ARE CURRENTLY TAKING:______________________

____

____

____

ALLERGIES

Do you have any allergies that you know of? (Please circle all that pertain to you)

Penicillin Sulfa Codeine Aspirin Latex Betadine/Iodine Tape

Anti-inflammatories Demerol Novocain General Anesthetics

List any other medications you are allergic to and the reaction you have:______________________

____

SURGICAL HISTORY

Please list any surgeries you have undergone: ______________________

____

Any problems with Anesthesia during surgery? YES/ NO If yes, please list problem: ______________________

HOSPTIALIZATION HISTORY

Hospitalization other than for the surgeries listed:

____

SOCIAL HISTORY

Do you smoke? ☐ YES ☐ NO # of packs per day __________

Previously smoked? ☐ YES ☐ NO # of years __________

Do you drink alcohol or beer? ☐ YES ☐ NO

If yes, please check one: ☐ Light; 1-2 per week ☐ Moderate; 1-2 per day ☐ More than 2 daily

Do you work? ☐ FULL TIME ☐ PART TIME ☐ RETIRED ☐ NONE

Does your employment require you to: ☐ SIT ☐ STAND AND WALK ☐ STAND

Type of shoe worn most: ☐ CASUAL (TENNIS SHOE) ☐ STEEL TOE ☐ DRESS

FAMILY HISTORY

Is there a family (blood relative) history of:

☐ Arthritis Who:__________ ☐ Bleeding Disorders Who:__________

☐ Cancer Who:__________ ☐ Diabetes Who:__________

☐ Stroke Who:__________ ☐ Bunions Who:__________

☐ Gout Who:__________ ☐ Flat feet Who:__________

☐ Hammertoes Who:__________ ☐ Heart Disease Who:__________

☐ Circulation problems Feet/leg Who:__________

Mother living: ☐ YES ☐ NO Cause of death:__________

Father living: ☐ YES ☐ NO Cause of death:__________

Brothers living: ☐ YES ☐ NO Cause of death:__________

Sisters living: ☐ YES ☐ NO Cause of death:__________

DO YOU HAVE HEART VALVE IMPLANTS? YES / NO DO YOU HAVE ANY ARTIFICIAL JOINTS OR LIMBS? YES / NO

If yes, WHICH and WHERE? ______________________

DO YOU USE OXYGEN: YES / NO

I authorize treatment and diagnostic procedures to be performed by Southern Oklahoma Podiatry Services, P.L.L.C. physicians and by members of the staff. I certify the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet/ankles.

Patient Signature:______________________ Date:__________

If a minor child; Parent/Guardian Signature:______________________ Date:__________

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my health and medical care, the Southern Oklahoma Podiatry Services, P.L.L.C., originates and maintains medical and health records describing my health history, symptoms, examination and the test results, diagnosis, treatment, and any plans for future care or treatment. I further understand this information serves as:

- a basis for planning my care and treatment
- a means of communication among the health professionals who contribute to my care
- a source of information for applying my diagnosis and treatment information to my bill
- a means for a third-party payer to verify that services were billed actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

Release of Information

I authorize the release of information including diagnosis, records, examination rendered to me and billing information. This information may be released to:

☐ Spouse:______________________________________

☐ Child(ren):____________________________________

☐ Other:____

☐ Information is not to be released to anyone.

Messages

Please call:
☐ home #__________________ ☐ work #____________________ ☐ cell#____________________

If unable to reach me:

☐ you may leave a detailed message
☐ please leave a message asking me to return you call
☐ other____

I request the following restrictions to the use and/or disclosure of my health information:__________________

By Oklahoma law we are required to notify you that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, disease such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

By signing this form, I agree that Southern Oklahoma Podiatry Services, P.L.L.C., may leave appointment reminders or medical information messages via phone, email, and fax information as appropriate for me with the information I have provided. Additionally, I give permission to request my prescription history. If permission is not given, I understand that I may be redirected for pain medication.

______________________________________ ____________________
Signature of Patient or Legal Representative Date