Premier Podiatry

KELEIGH MUXLOW, DPM - NEW PATIENT FORM

Preferred First Name: _____ Last Name: _____ MI:_____

Address: _____ City: _____

E-mail:_____ Birth Date: ____/____/_____ Age _____

Home Number: (____) _____

Emergency Contact:_____ Phone : (____) _____

Family Physician: _____ Phone Number: (____) _____

Fax Number: (____) _____

Pharmacy: _____ Pharmacy Phone: (____) _____

Address: _____ City: _____

HOW DID YOU HEAR ABOUT US : Doctor Referral ☐ **Insurance** ☐ **Friend/Family** ☐ **Internet/Google** ☐

Referred by:_____ Other:_____

Advanced Directive (Age 65 or Older) Please circle one

No Decision Maker/Surrogate Decision Maker/ No Decision maker discussed/ Power of Attorney

RELEASE OF PERSONAL INFORMATION TO THE PATIENT'S DESIGNEES

I authorized medical staff members of this practice to discuss my medical history, diagnosis, treatment and prognosis with other medical providers and organizations that participate in care and with those listed below.

Name Phone Number Relationship

_____

_____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits and services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ , herby authorize_____ to pay and hereby assign directly to KELEIGH MUXLOW, DPM all benefits. I further acknowledge that any insurance benefits, when received by and paid to KELEIGH MUXLOW, DPM will be credited to my account in accordance with the above said assignment.

Agreed & Authorized: _____ **Date**: _____

SOCIAL HISTORY Do or Did you

smoke cigarettes? ☐Yes ☐No If Yes, packs per day?_____ Stop date: _____

Drink alcohol regularly? ☐Yes ☐No Do you exercise regularly? ☐Yes ☐No

Allergies to any medication? ☐Yes ☐No If Yes, which medications? _____

Please list ALL medications you are currently taking: _____

_____

_____

_____

MEDICAL HISTORY (Last 5 years)

Previous Surgery/Hospitalizations_____

_____

Blood Transfusions (dates): _____ General Anesthesia:_____

Injuries and Fractures (types & dates):_____

SYSTEMIC REVIEW (DO YOU NOW HAVE OR EVER HAD THE FOLLOWING)

	YES	NO		YES	NO
Chronic Headaches/Migraines			**Diabetes**		
Dizziness			**High Blood Pressure**		
Fainting Spells/Blackouts			**High Cholesterol**		
Eye Disease/Glaucoma/Cataracts			**Joint Pains/Swelling**		
Double Vision			**Numbness/Tingling of hand/Feet**		
Recent Vision Impairment			**Color Changes in the Hands**		
Impaired Hearing			**Chest Pressure/Chest Pain**		
Ringing in the Ears			**Chronic Back Pain**		
Dryness of __ Eyes __Mouth			**Chronic Neck Pain**		
Recent Hair Loss			**Parkinsonism**		
Asthma			**Heart Murmur**		
Difficulty Breathing			**Cancer**		
Coughing Up Blood			**Hepatitis/Jaundice**		
Rheumatic Fever			**HIV Virus Positive**		
Difficulty Urinating			**Chronic Anxiety**		
Painful/frequent Urination			**Depression**		
Blood in Urine			**Gout**		
Nighttime Urination _____times			**Neuropathy**		
Prostate Disorder			**Bleeding Tendency**		
Recurring Bladder Infections			**Multiple Sclerosis**		
Kidney Disease/Stones			**Low Back Pain**		
Pancreatitis			**Leg Cramps**		
Current Pregnancy					
Circulatory Problems					
Stents					

Date of: Most Recent Medical Exam_____

EKG_____Blood Tests_____Chest X-Ray_____

List all current medical conditions:_____

_____

Reason for office visit today._____

_____

Shoe Size: _____Height: _____ Weight(lb): _____