



KEYSTONE PODIATRIC

MEDICAL ASSOCIATES, P.C.

Foot & Ankle Disorders & Surgery
Adults & Children

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23 N. Main St. Biglerville, PA 17307
(717) 677-9288 Fax (717) 677-4196

DILLSBURG FOOT & ANKLE CENTER
28 Barlo Circle, Dillsburg, PA 17019
(717) 502-8181 Fax (717) 502-8183

LONDONDERRY FOOT & ANKLE CENTER
4303 Londonderry Road, Harrisburg, PA 17109
(717) 652-5811, Fax (717) 541-1161

PAXTONIA FOOT & ANKLE CENTER
6100 Old Jonestown Rd., Harrisburg, PA 17112
(717) 541-0988, Fax (717) 541-8838

Welcome To Our Office

Patient Account #:

FOR OFFICE USE ONLY: CHANGE OF PATIENT INFORMATION

_____ _____ _____ _____
Date Date Date Date

Last Name First Name Middle Initial Birth Date Age

Residence Address City State Zip

Home Phone No. Social Security No. Driver's License Number
Cell Phone No. Email Address (For Receipt of Practice or Educational Information)

Sex Marital Status Patient's Employer/Business Work No.
 M F Single Married Widowed Divorced

If married, spouse's name Spouse's Employer/Business Spouses work phone Are there any legal documents with special guidelines/ instructions for patient?
 No Yes If yes, please supply us a copy.

If applicable, name of parent(s)/guardian(s)/caregiver(s) Address Telephone No.
1. 1. (H)- (W)-

2. 2. (H)- (W)-

Check appropriate box and name referral source
 Doctor _____ Health Fair _____
 Another Patient _____ Yellow Pages _____
 Other _____

Person to contact in case of an emergency Relationship Phone

Name of nearest relative not living with you Address Phone

Name of family physician Address Phone Fax

FOR OFFICE USE ONLY: CHANGE IN PHYSICIAN INFORMATION

_____ _____ _____ _____
Date Date Date Date

INSURANCE INFORMATION

Name and address of person responsible for this account Birth Date Do you have medical insurance? Yes No Is this through your employer? Yes No
Is this through your spouse? Yes No

Primary Insurance Policy Holder Policy Holder's Birth Date Policy Holder's Place of Employment

Secondary Insurance Policy Holder Policy Holder's Birth Date Policy Holder's Place of Employment

FOR OFFICE USE ONLY: CHANGE IN INSURANCE INFORMATION

_____ _____ _____ _____
Date Date Date Date

I hereby give my permission to Keystone Podiatric Medical Associates to administer treatment and to perform such minor procedures as may be deemed necessary in the diagnosis and /or treatment of my foot and leg condition.

I understand and agree that, regardless of my insurance status, I will be held responsible for the balance on my account and responsible for any services deemed not covered by the insurance company since my insurance coverage is a contract between myself and my insurance company.

I have read all the information on both sides of this sheet and have completed all of the above questions.

I certify that this information is true and correct to the best of my knowledge and will notify you of any changes.

PATIENT SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

Are you currently under your physician's care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Height	Weight	Shoe size	Last blood sugar	Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No How much?
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List any medical conditions you have (special conditions, impairments, etc.)

List any previous surgeries:

Have you had previous treatment by a Podiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No	When:	For What:
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My chief foot complaint is:

This condition has existed for how long?

Do you have any or have had the following:

YES NO

Foot or Leg Injuries	<input type="checkbox"/>	<input type="checkbox"/>
Foot or Leg Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Foot or Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Foot or Leg Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>
Unequal Leg Length	<input type="checkbox"/>	<input type="checkbox"/>
Weak Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Bunions	<input type="checkbox"/>	<input type="checkbox"/>
Foot Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
Toe Nail Problems	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>

Are you allergic or sensitive to:

YES NO

Novocaine	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Adhesive Tape	<input type="checkbox"/>	<input type="checkbox"/>
Materials	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Foods	<input type="checkbox"/>	<input type="checkbox"/>
Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>
Latex.....	<input type="checkbox"/>	<input type="checkbox"/>
Other (if so describe)	<input type="checkbox"/>	<input type="checkbox"/>

Do you have or had you had any of the following:

YES NO

Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problems (i.e. Asthma, TB)	<input type="checkbox"/>	<input type="checkbox"/>

YES NO

Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>
Bleeder	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>
Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>
Hardening of Arteries	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Prone to Infection	<input type="checkbox"/>	<input type="checkbox"/>
HIV (Human Immunodeficiency Virus) ...	<input type="checkbox"/>	<input type="checkbox"/>