PALMETTO PODIATRY ASSOCIATES, LLC

Joseph J. Moran, DPM
Karen M. Moon, DPM
1730 Henderston Street, Suite B
Columbia, SC 29201
(803) 376-1717

Please provide your insurance cards and a photo ID

Date:	Referring Doctor:	
Patient Last Name:	First Name:	MI:
Address:	City/ST/Zip:	
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )
Sex: ☐ M ☐ F	SSN:	Date of Birth:
Please check all means of communication you authorize our office to use:	☐ home phone ☐ cell phone ☐ work phone ☐ text ☐ email ☐ all of the above	
E-mail:		
Employer/School Address & Phone:		
Family Doctor:	Phone Number: ( )	

What chief complaint are you having with your foot/feet?	
How long have you had this problem?	
What previous treatment (if any) have you had?	
Is your problem due to an injury? Yes ☐ No ☐	Are you presently under a doctor's care? Yes ☐ No ☐
If you are presently under a doctor's care, for what reasons?	
What is the date of your last physical?	

For insurance billing:

I HEREBY AUTHORIZE PALMETTO PODIATRY ASSOCIATES, LLC TO FURNISH MY INSURANCE COMPANY ALL INFORMATION WHICH THE INSURANCE COMPANY MAY REQUEST CONCERNING MY PRESENT ILLNESS OR INJURY. I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO PALMETTO PODIATRY ASSOCIATES, LLC AND I AM PERSONALLY RESPONSIBLE FOR ANY NON-COVERED SERVICES OR ITEMS.

I GIVE PERMISSION FOR DR. MORAN/DR. MOON TO RENDER TREATMENT AS DEEMED MEDICALLY NECESSARY AND APPROPRIATE. THE FACT THAT I AM AT PALMETTO PODIATRY ASSOCIATES, LLC FOR TREATMENT IMPLIES MY CONSENT FOR RECOMMENDED PROCEDURES.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

Authorized Representative for Patient: _____

Authorized Representative's printed name: _____ Relationship to patient: _____

Please check if you have ever experienced any of the following conditions:

☐ Diabetes	☐ Circlulation Problems	☐ Arthritis	☐ Kidney Disease
☐ Anemia	☐ High Blood Pressure	☐ Liver Disease	☐ Heart Condition
☐ Blood Clot	☐ Phlebitis	☐ Asthma	☐ Bowel/Stomach Problems
☐ Ulcers	☐ Gout	☐ HIV Disease	☐ Cancer
☐ Migraines	☐ Hepatitis	☐ Lung Disease	What kind:
☐ Other:	☐ Stroke	☐ Alzheimer's	

Are you pregnant or think you might be pregnant? ☐Yes ☐No

Please list any medications to which you are allergic:

_____

Please list any recent hospitalizations:

Please list all medications you are presently taking:

_____

Pharmacy Name & Address: Pharmacy Phone: ( )

Do you smoke? ☐Yes ☐No If yes, how much?

If No, have you ever smoked? ☐Yes ☐No

Do you drink? ☐Yes ☐No If yes, how much?

Do you use any recreational drugs? ☐Yes ☐No If yes, what kind?

How did you hear about us?