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 circle 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 circle if you have ever experienced any of the following conditions:

Diabetes	Circulation Problems	Arthritis	Kidney Disease
Anemia	High Blood Pressure	Liver Disease	Heart Condition
Blood Clot	Phlebitis	Asthma	Bowel/Stomach Problems
Ulcers	Gout	HIV Disease	Cancer What kind:
Migraines	Hepatitis	Lung Disease	
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?