Lebanon Valley Foot & Ankle Center
Dr. Christopher A. Seda, DPM, FACFAS
840 Helen Drive
Lebanon, PA 17042
(717) 273-6040

Name: _____

Date of Birth: _____ **Age:** _____ **Social Security Number:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: _____ **Cell Phone #:** _____

Employer: _____ **Work Phone #:** _____

Emergency Contact: _____ **Phone #:** _____ **Cell Phone #:** _____

Primary Care Physician: _____ **Primary Care Physician's Phone #:** _____

Insurance Information

****ALL COPAYS ARE PAYABLE UPON OFFICE VISIT****

Primary Insurance:	Secondary Insurance:
Policy Holder's Name:	Policy Holder's Name:
Policy Holder's DOB:	Policy Holder's DOB:
Social Security #:	Social Security #:
Policy #:	Policy #:
Group #:	Group #:

Podiatric History

Please describe your foot/ankle problem (include date of injury if applicable):

_____

Have you seen a podiatrist in the past? ___No ___Yes Whom? _____ Last Visit _____

Have you had any prior foot/ankle problems? If yes, please describe: _____

Please indicate which foot problems you now have or have had in the past:

Ankle Pain	Athlete's Foot	Bunions	Corns/Calluses	Cramps/Numbness	Flat Feet
Heel Pain	Ingrown Toenails	Plantar Warts	Swelling	Tired Feet	Other

PLEASE TURN OVER – QUESTIONNAIRE CONTINUED

Medical History

Please circle all that apply to you now or have applied to you in the past

AIDS/HIV	Allergies	Anemia	Angina	Arthritis	Artificial Heart Valve/Joints
Asthma	Back Problems	Bleeding Disorders	Cancer	Chemical Dependency	Chest Pain
Chronic Diarrhea	Circulatory Problems	Diabetes	Ear Problems	Epilepsy	Eye Problems
Fainting	Foot/Leg Cramps	Gout	Headaches	Heart Disease	Hemophilia
Hepatitis or Jaundice	High Blood Pressure	Kidney Problems	Liver Disease	Low Blood Pressure	Neuropathy
Phlebitis	Psychiatric Care	Radiation Treatment	Rash	Respiratory Disease	Rheumatic Fever
Shortness of Breath	Sinus Problems	Special Diet	Stroke	Swelling in Ankles/Foot	Swollen Neck Glands
Tired Feet	Tuberculosis	Ulcers	Varicose Veins	Venereal Disease	Weight Loss (unexplained)

Surgical History

Procedure	Date	Physician	Hospital

Medications & Dosages/Allergies

****Please List on Yellow Patient Intake Form or Supply a List****

Authorization/Financial Agreement

I hereby authorize Christopher A. Seda, DPM, FACFAS (and the doctor's assistants or designated replacement) to administer and perform such procedures deemed necessary in the diagnosis and/or treatment of my extremity condition.

I hereby authorize direct payment of surgical and medical benefits on my behalf to the provider of these services that would otherwise be payable to me for services rendered. I understand that I am personally responsible to the physician for charges not covered by my insurance agreement.

I give Christopher A. Seda, DPM, FACFAS (and the doctor's assistants or designated replacement) permission to obtain and release medical information to/from insurance companies, hospitals, and referring physicians by fax, mail, or phone.

I agree to pay interest on the unpaid balance as well as collection expenses, which may include reasonable attorney fees.

The information provided by me is true to the best of my knowledge. I have read the following, understand, and agree to the office policy.

Date: _____ **Signature of Patient or Legal Guardian** _____

If not patient, please check relationship __**Parent** __**Legal Guardian**

__**POA** __**Other** _____