Practice of
Louis R. MacDonald, DPM, PC; Meenakshi Singhal, DPM;
Alex Mand, DPM; Sean Lynch, DPM; Duan Zhang, DPM

Today's Date:_____

Name: _____ **DOB:** _____ **SSN:** _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse/Partner Name: _____

E-Mail: _____

CellPhone #: _____ **Home Phone #:** _____ **Other:** _____

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

Emergency Contact Name: _____ **Phone:** _____

Employer: _____ __ **Employer Phone Number:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Insurance: _____ Are you the insured?: ☐ Yes ☐ No

Subscriber Name: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber Phone #: _____ DOB: _____ Sex: ☐ Male ☐ Female

Subscriber Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured?: ☐ Yes ☐ No

Subscriber Name: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber Phone #: _____ DOB: _____ Sex: ☐ Male ☐ Female

Subscriber Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

How did you hear of our office? ☐ Physician ☐ Google ☐ Facebook ☐ Family Member ☐ Friend ☐ Insurance

☐ Other Internet: _____ ☐ Other: _____

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits and Acknowledgements): I authorize payment of medical benefits to the practice named above. I authorize the release of any medical information necessary to process claims. I certify I will pay to the practice co-payments, co-insurance, deductibles or cost of non-covered products or services. I will promptly pay to the practice any payments that I receive from my insurance carrier for services provided to me and/or my dependents. I will also be responsible for any amounts not paid by insurance if I fail to provide appropriate insurance information for billing or fail to secure the appropriate referrals. (Method of contact): I agree that the practice named above, its affiliates, and those acting on its behalf, may call, text or email me. They may use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due or any other healthcare related function. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me. (HIPPA Privacy): I acknowledge that I received my HIPPA Privacy Practices Notice. (Medical Records): I authorize the release of my medical records from prior and concurrent physicians, podiatrist, and other health professionals to the above doctors. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature:_____ Date:_____

Practice of
Louis R. MacDonald, DPM, PC; Meenakshi Singhal, DPM;
Alex Mand, DPM; Sean Lynch, DPM; Duan Zhang, DPM

Name: **DOB:** **Date:**

Medical History:

☐ Diabetes Type 1	☐ Heart Attack	☐ COPD	☐ Stroke	☐ HIV
☐ Diabetes Type 2	☐ Heart Disease	☐ Asthma	☐ Blood clot	☐ Depression
☐ Alcoholism	☐ High blood pressure	☐ Allergies	☐ Blood disorders	☐ Anxiety Disorder
☐ Hepatitis	☐ A Fib	☐ Sleep apnea	☐ GERD	☐ Mental illness
☐ Liver Disease	☐ High cholesterol	☐ Breathing issues	☐ Stomach ulcer	☐ Dementia
☐ Kidney Disease	☐ Heart murmur	☐ Gout	☐ Bowel obstruction	☐ Sciatica
☐ On Dialysis	☐ Circulation Problems	☐ Skin disorders	☐ IBS	☐ Lyme's Disease
☐ Thyroid Disease	☐ Osteoporosis	☐ Psoriasis	☐ Glaucoma	☐ COVID 19

☐ Neuropathy (Specify) _____ ☐ Cancer _____

☐ Arthritis (Specify) _____

☐ other:

Current Medications

☐ No Medications ☐ See attached list

☐ I take the following medications

Name:_____

Name:_____

Name:_____

Name:_____

Name:_____

Use the back of this form if more room is needed

Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Use the back of this form if more room is needed

Pharmacy_____

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

Smoking Status:

☐ Current Every Day ☐ Smoker, Current status unknown ☐Unknown if ever ☐ Never

☐ Current Some Day ☐ Heavy Tobacco ☐Light tobacco ☐ Former

Do you drink alcohol? ☐ Yes, everyday (5-7days/week) ☐ Yes, socially/occasionally ☐ No/Rarely

Have you ever had a substance abuse problem? Please specify:_____

Last Flu Shot Date: _____ **Pneumonia vaccine?** ☐ Yes ☐ No

Do you have any advanced directives? ☐ No ☐ Living will ☐ Power of Attorney ☐ Do Not Resuscitate

☐ Surrogate Decision Maker:_____

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature:_____ Date:_____

Practice of
Louis R. MacDonald, DPM, PC; Meenakshi Singhal, DPM;
Alex Mand, DPM; Sean Lynch, DPM; Duan Zhang, DPM

Name: **DOB:** **Date:**

What is the reason for your appointment today? _____
_____ **Result of accident or work injury?** ☐ Yes ☐ No

How long has this bothered you? _____

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? _____/10

The pain quality is: ☐ burning ☐ throbbing ☐ constant ☐ dull ☐ sharp ☐ shooting ☐ tingling ☐ other:_____

What shoe size do you wear? _____ **Height**_____ **Weight**_____

Primary Care Physician:_____ Date last seen:_____

Address:_____ Phone Number:_____

Endocrinolgist:_____ Date last seen:_____

Address:_____ Phone Number:_____

Cardiologist:_____ Date last seen:_____

Address:_____ Phone Number:_____

Vascular Surgeon:_____ Date last seen:_____

Address:_____ Phone Number:_____

Review of Systems

Cardiovascular	☐ fever ☐ leg swelling	☐ chest pain / pressure ☐ leg pain when walking	☐ cold hands/feet ☐ fainting	☐ palpitations ☐ vascular disease	☐ valve problems ☐ NONE
Genitourinary	☐ blood in urine ☐ hesitancy	☐ decreased frequency ☐ increased urgency	☐ incontinence	☐ excessive urination ☐ kidney disease	☐ kidney stones ☐ NONE
Gastrointestinal	☐ abdominal pain ☐ diarrhea	☐ heartburn ☐ Trouble swallowing	☐ blood in stool ☐ vomiting	☐ ulcers ☐ decrease appetite	☐ constipation ☐ NONE
Integumentary	☐ athletes foot	☐dry, scaly skin	☐ keloids	☐ itchiness	☐ NONE
Hematologic	☐ clotting disorders	☐ sickle cell disease	☐ anemia	☐ blood thinners	☐ NONE
Neurological	☐ tingling ☐ tremors	☐ weakness ☐ paralysis	☐ seizures ☐ numbness	☐ headaches	☐ NONE
Musculoskeletal	☐ back pain ☐ sciatica	☐ joint swelling ☐joint stiffness	☐ muscle weakness ☐ muscle pain	☐ arthritis ☐ neck pain	☐ joint pain ☐ NONE
Respiratory	☐ chest pain ☐ shortness of breath	☐ wheezing ☐ emphysema	☐ COPD ☐ coughing	☐ snoring	☐ NONE

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature:_____ Date:_____