APPLE HILL PODIATRY ASSOCIATES, P.C.

DEE STELMACH, D.P.M., FACFAS
DAVID F. BASKWILL, D.P.M., FACFAS, FACFO
STACIE S. SMITH, D.P.M.

Patient Information Update Form

PLEASE PRINT TODAY'S DATE_____

NAME_____ MARITAL STATUS: S M W D BIRTHDATE_____

ADDRESS_____ HOME TELEPHONE #_____ AGE_____

CITY_____ STATE_____ ZIP_____ EMPLOYER_____ WORK #_____

PATIENT HISTORY

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING: (ANSWER YES OR NO TO ALL)

ASPRIN_____ IODINE_____ SULFA DRUGS_____ LATEX_____ OTHER_____
ADHESIVE TAPE_____ PENICILLIN_____ NOVACAINE_____ OTHER_____ OTHER_____

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING: (ANSWER YES OR NO TO ALL)

DIABETES_____ HEART TROUBLE_____ ASTHMA_____ THYROID DISORDERS_____
ARTHRITIS_____ KIDNEY DISEASE_____ HIGH BLOOD PRESSURE_____ OTHER_____
EPILEPSY_____ BLADDER TROUBLE_____ AIDS OR HIV +_____ OTHER_____
BLOOD CLOTS_____ STOMACH TROUBLE_____ CLOTTING DISORDERS_____ OTHER_____

PLEASE LIST ALL SURGERY THAT YOU HAVE HAD:

TYPE OF SURGERY	DATE OF SURGERY
1._____	_____
2._____	_____
3._____	_____
4._____	_____

PLEASE LIST ANY RECENT HOSPITALIZATIONS:

1._____ _____
2._____ _____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING;

1._____ 2._____ 3._____
4._____ 5._____ 6._____

PRIMARY INSURANCE

Policy Subscriber:

NAME_____ MARITAL STATUS: S M W D SEX: M F
ADDRESS_____ CITY_____ STATE_____ ZIP_____
HOME TELEPHONE #_____ BIRTHDATE_____ AGE_____
INSURANCE I.D. #_____ EMPLOYER_____ WORK #_____
EMPLOYER ADDRESS _____

SUBSCRIBER EMPLOYMENT STATUS:

STUDENT_____ FULL TIME EMPLOYED_____ NOT EMPLOYED_____
PART TIME EMPLOYED_____ SELF EMPLOYED_____ RETIRED_____
IS THE POLICY SUBSCRIBER: PATIENT_____ SPOUSE _____ PARENT/GUARDIAN _____OTHER _____
INSURANCE COMPANY NAME_____
GROUP NUMBER_____ Do you have a COPAY (yes/no)? _____ COPAY Office Visit Amount? _____
Do you have a DEDUCTIBLE (yes/no)? _____ DEDUCTIBLE Amount? _____ Do you have a COINSURANCE % PAYMENT (yes/no)? _____ COINSURANCE % _____

SECONDARY/OTHER INSURANCE

Policy Subscriber:

NAME_____ MARITAL STATUS: S M W D SEX: M F
ADDRESS_____ CITY_____ STATE_____ ZIP_____
HOME TELEPHONE #_____ BIRTHDATE_____ AGE_____
INSURANCE I.D. #_____ EMPLOYER_____ WORK #_____
EMPLOYER ADDRESS _____

SUBSCRIBER EMPLOYMENT STATUS:

STUDENT_____ FULL TIME EMPLOYED_____ NOT EMPLOYED_____
PART TIME EMPLOYED_____ SELF EMPLOYED_____ RETIRED_____
IS THE POLICY SUBSCRIBER: PATIENT_____ SPOUSE _____ PARENT/GUARDIAN _____OTHER _____
INSURANCE COMPANY NAME_____
GROUP NUMBER_____ Do you have a COPAY (yes/no)? _____ COPAY Office Visit Amount? _____
Do you have a DEDUCTIBLE (yes/no)? _____ DEDUCTIBLE Amount? _____ Do you have a COINSURANCE % PAYMENT (yes/no)? _____ COINSURANCE % _____