Feet First Podiatry

Dr. Ellen Mady * Dr. Philip Watkins
Podiatric Physicians and Surgeons

Family History

Mother – Living or Deceased _____
Health concerns or diseases _____

Father – Living or Deceased _____
Health concerns or diseases _____

Social History

Height _____ Weight _____
Smoker - Current – Never - Former - Packs per day / week _____ Number of years _____
Drink Alcohol – No / Yes Number of drinks per week _____ Number of years _____

Is there anything else you would like the doctor to know about your health?

_____

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Assignment of Benefits / Privacy Practices

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN: I hereby authorize payment directly to Dr. Mady or Dr. Watkins, the surgical and or medical benefits.
Signature _____ Date ___/___/____

NOTICE OF PRIVACY PRACTICES: I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the notice.
Signature _____ Date ___/___/____