

## PATIENT MEDICAL HISTORY REQUEST – ESWT FOR CHRONIC PROXIMAL PLANTAR FASCIITIS

Patient Name: \_\_\_\_\_

Patient Age: \_\_\_\_\_ Patient Gender: \_\_\_\_\_

Length of time suffering from the onset of Chronic Proximal Plantar Fasciitis:  
\_\_\_\_\_ months or years. (Circle one)

I have tried the following conservative treatments without relief. (Circle all that apply)

Cortisone Injections	Foot Supports (Orthotics)	Night Splints
Physical Therapy	NSAIDS	Stretching
		Changes in Foot Gear

Please provide a medical history of your condition with how it affects your personal life and your work, i.e., can no longer exercise, unable to stand for long periods of time and job requires standing. Please list all types of treatments, prescribed and not prescribed, that you have tried for your condition. Please try to include dates. Include all medications that you have tried, prescribed and not prescribed. List all devices, prescribed and not prescribed, that you have tried. Have any of the treatments helped with your symptoms in any way?

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Insurance Release for Procedure and Authorization and Payment: I hereby authorize the physician to release to Shockwave Specialists of the Carolinas, LLC any information acquired in the course of medical information of treatment including but not limited to information regarding psychiatric, HIV treatment and/or testing. A photocopy of this authorization shall be considered as valid as the original.

Authorization to pay benefits: I hereby authorize Shockwave Specialists of the Carolinas, LLC to process and receive medical payment for all medical benefits from insurance companies for the Orthotripsy procedure. I recognize my financial obligation to pay any co-payments, insurance deductible and non-covered services as required.

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

Above information will be kept confidential and used only to acquire insurance coverage for ESWT.