Treasure Coast Podiatry

Paul Gotkin, D.P.M.**
David Gubernick, D.P.M., P.A.*
Scott Parratto, D.P.M.***
MaiKhoi Pham, D.P.M.
*Diplomates, American Board of Podiatric Surgery &
Fellows, American Board of Foot and Ankle Surgery
**Diplomate, American Board of Laser Surgery
*** Certified Wound Care Specialist

Welcome to Our Office

Please Print the following Information:

Patient's Name: Today's Date: _____

Last_____ First_____ Middle Initial_____

Address: _____
Number and Street City State Zip Code

Home Phone#_____ Can we leave confidential information at this number Yes __ No __

Cell Phone # _____ Work Phone #_____

Sex: ___Male ___ Female Date of Birth _____ SS#_____Age:_____

Marital Status: __Single __Married __Widowed __Separated __Divorced

Race: _____ **Ethnicity:** _____ **Preferred Language:** _____

If Patient is a Minor:

Parent's Name _____Date of Birth_____SS#_____

Employment Information (for patient or parent if patient is a minor)

Employer:_____Occupation:_____Phone_____

Preferred Pharmacy/Laboratory_____**Phone**_____

Insurance Name:_____ **Member ID:**_____

Subscriber Name:_____DOB_____SS#_____

How did you hear about our office?_____

What is the reason for your visit?_____

Was the condition the result of an accident? Yes____ No____ if yes, did it happen at __Work __Home __Other

Accident details: _____

Who is the Primary Care Physician? _____Phone #_____
(Please print first and last name)

Height _____ Weight _____ Shoe Size _____

Current Medications: _____

_____

_____

Surgical History: _____

_____

Allergies:
__Aspirin __Local Anesthetics
__Codeine __Penicillin
__Demerol __Sulfa
__Iodine __Adhesive tape
__Latex __Seafoods

__I have no known allergies

Other Allergies_____

Social History:
Tobacco use: __Yes __No How much? _____
Alcohol Use: __Yes __No How much?_____

Medical and Family History

Please check all that apply under the **Patient** for the patient history and under **Mother/Father** for family history.

	Patient	Mother	Father		Patient	Mother	Father
Aids/HIV				Weight Change			
Arthritis/joint pain				Fever/Chills			
Bleeding Disorders/anemia				Depression/Anxiety			
Sickle Cell				Osteoporosis			
Foot/Leg Ulcers				Swelling of feet			
Diabetes				Stomach Ulcer/Reflux			
Heart Disease				Liver Disease/Hepatitis			
Foot or Leg Cramps				Kidney Disease			
High Blood Pressure				Cancer; Type			
Muscle Weakness/Pain				Joint Replacement - Where			
Numbness/Tingling/Burning				Mitral Valve Prolapse			
Rashes				Thyroid Disease			
Phlebitis				Varicose Veins			
Blood Clots							

Please List Current Medical Conditions: _____

_____

_____

HIPPA Authorization on file

Please list the family members or significant others, if any, whom we may inform about your medical condition

Name:_____Phone #_____

Name:_____Phone #_____

Secondary Address: _____

Number and Street City State Zip Code

By Signing below:

~ I authorize release of information to all my insurances
~ I understand that I am ultimately responsible for my bill
~ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers
~ I authorize payment directly to my doctor
~ I acknowledge that the Notice of Privacy Practices is displayed on the wall in the reception area and a copy is available to me at my request
~ I hearby authorize Dr. Paul N. Gotkin, Dr. David A. Gubernick, Dr. Scott F. Parratto or any other person under their direction to administer treatment including anesthetics, injections, surgical procedures, casting or x-rays as may be deemed necessary. The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to results that may be obtained.
~ I understand that there are no guarantees whatsoever regarding the successful outcome of surgical procedures, orthotics, braces, shoes or appliances

I have read the above listed information and fully understand my responsibility.

Date _____ Signature:_____(parent if patient is a minor)

Date_____ Witness Signature: _____