

# TREASURE COAST PODIATRY

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WELCOME TO OUR OFFICE

PLEASE PRINT THE FOLLOWING INFORMATION

PATIENT'S NAME:

TODAY'S DATE: \_\_\_\_\_

Last

First

Middle

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

Birth Date: \_\_\_\_\_

SS# \_\_\_\_\_

Age: \_\_\_\_\_

Marital Status:  Single

Married

Widowed

Separated

Divorced

IF PATIENT IS A MINOR:

Parent's Names: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SS#: \_\_\_\_\_

EMPLOYMENT INFORMATION (for patient or parent if patient is a minor):

Employer \_\_\_\_\_

Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

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

Who is your 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

## SOCIAL HISTORY

Other Allergies \_\_\_\_\_

Tobacco use  Yes  No

Alcohol use  Yes  No

**MEDICAL AND FAMILY HISTORY**

Please check all which apply under **Patient** for the patient history and under **Family** for family history.

	Patient	Family	Patient	Family	Patient	Family
AIDS/HIV			Dizzy Spells/Fainting		Mitral Valve Prolapse	
Arthritis			Epilepsy		Nervous Problems	
Artificial Heart Valves or Joints			Fever		Numbness in Feet	
Back Problems			Foot or Leg Cramps		Rash	
Bleeding Disorders			G I Disorders		Respiratory Disease	
Blood Clots			Glaucoma		Stroke	
Burning in Feet			Gout		Swelling Feet/Ankles	
Cancer			Heart Disease		Tumors	
Chest Pain			Hepatitis or Jaundice		Ulcers	
Circulatory Problems			High Blood Pressure		Unexplained Weight Loss	
Cold Feeling in Feet (Continually)			Kidney Problems		Varicose Veins	
Diabetes						
Other						

**HIPPA AUTHORIZATION OF FILE**

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

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

If other than your home phone number, please print the phone number of where you would like to receive calls about your appointments, labs and x-ray results, or other health care information. Phone #: \_\_\_\_\_

Can confidential messages (i.e. Appointment reminders) be left on your home answering machine or voicemail? Yes \_\_\_ No \_\_\_  
 Can messages be left with any person answering your home phone? Yes \_\_\_ No \_\_\_  
 Can we contact you or leave messages at your work number? Yes \_\_\_ No \_\_\_

**BY SIGNING BELOW:**

- I authorize release of information to all my insurances.
- I understand 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 hereby authorize Dr. Paul N. Gotkin, Dr. David A. Gubernick, Dr. Scott F. Parratto or any other person under their direction to administer treatment including local 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 acknowledge 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: \_\_\_\_\_