



Treasure Coast Podiatry

PAUL GOTKIN, D.P.M.**
DAVID GUBERNICK, D.P.M., P.A.*
SCOTT PARRATTO, D.P.M.***

ANDREW D. LONABAUGH, D.P.M.
SCOTT COHEN, 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? _____

