



ATLANTIC PODIATRY

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/___/___

PATIENT NAME: _____ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE USING THE FOLLOWING ?

HOME PHONE #: (____) ____-____ YES NO

CELL PHONE #: (____) ____-____ YES NO TEXT APPOINTMENT REMINDER YES NO

E-MAIL: _____ YES NO

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN-AGE(S) _____ ☐ PET(S)-WHAT KIND? _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (____) ____-____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____-____

PRIMARY CARE DOCTOR: _____ WHO REFERRED YOU TO US? _____

PHARMACY: _____ LOCATION: _____ PHONE #: (____) ____-____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

____ YES NAME(S) _____

____ NO

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT - HOW LONG AGO? _____ ☐ SMOKE _____ PACKS/DAY FOR _____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT - HOW LONG AGO? _____ TYPE _____

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE

☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS

☐ OTHER _____

ALLERGIES:

MEDICATIONS: Prescription and nonprescription medicines, include herbal medications or Attach list

NAME	DOSE	HOW OFTEN DO YOU TAKE?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HAVE YOU HAD:

Problems with your heart ? (check all that apply)

- ☐ Blood pressure or related problems 401.9
- ☐ Heart Attack (MI) 410.9
- ☐ Angina 413.9
- ☐ Congestive Heart Failure 428.0
- ☐ Arrhythmia (irregular heart beat) 427.8
- ☐ Coronary artery disease 411.89
- ☐ Peripheral vascular disease (poor circulation) 440.2
- ☐ Blood clot in leg (DVT) 454.1
- ☐ High Cholesterol 272.4
- ☐ Other _____

Problems with your skin ? (check all that apply)

- ☐ Cellulites (skin infection) 682.9
- ☐ Psoriasis 696
- ☐ Skin Cancer 173
- ☐ Excessive scarring 709.2
- ☐ Shingles (zoster) 053
- ☐ Chronic recurrent athletes foot (tinea pedis) 110.9
- ☐ Thick or discolored nails 757.5
- ☐ Other _____

Endocrine Problems ? (check all that apply)

- ☐ Diabetes 250
- ☐ Hypothyroid (low thyroid -- common) 244.9
- ☐ Hyperthyroid (high thyroid—less common) 242.90
- ☐ Other _____

Genetic/Congenital disorders ? (check all that apply)

- ☐ Trisomy 21 (down syndrome) 758.0
- ☐ Learning disabilities 315.2
- ☐ Sickle cell 282.60
- ☐ Other _____

Gastrointestinal Problems ? (check all that apply)

- ☐ Reflux (GERD) 530.81
- ☐ Peptic Ulcer disease 533
- ☐ Liver disease (type _____) 575.
- ☐ Cholecystitis (gallblader disease) 575.1
- ☐ Diverticulitis 562
- ☐ Colon cancer 153.9
- ☐ Other _____

Problems with your eyes, ears, nose, throat

- ☐ Glaucoma 365.9
- ☐ blindness 369.00
- ☐ deafness 389.9
- ☐ vertigo 438.85
- ☐ Macular Degeneration 362.5
- ☐ Other _____

Problems with your lungs ? (check all that apply)

- ☐ Asthma 493
- ☐ COPD 496
- ☐ Emphysema 492
- ☐ Sleep apnea 327.23
- ☐ Chronic bronchitis 490
- ☐ Lung cancer 165.9
- ☐ Pneumonia 486
- ☐ Other _____

Problems with your blood or kidneys? (check all that apply)

- ☐ Anemia 285.9
- ☐ Difficulty stopping bleeding 286
- ☐ Use of blood thinners 286.7
- ☐ lymphoma 202
- ☐ Kidney disease 585
- ☐ Dialysis 585.6

Problems with your Immune System

- ☐ Organ Transplant (Specify _____) v45.87
- ☐ Lupus 695.4
- ☐ anaphylactic reaction (to what _____)v49.0
- ☐ HIV/AIDS 042
- ☐ Other _____

Musculoskeletal Problems ? (check all that apply)

- ☐ Osteoarthritis (degenerative joint disease) 715
- ☐ Rheumatoid arthritis 714.0
- ☐ other arthritis (Specify _____)
- ☐ Gout 274.9
- ☐ Spinal stenosis 724.0
- ☐ Sciatica 724.3
- ☐ Herniated disks (back or neck) 722.6
- ☐ Amputation (specify _____)v49.0
- ☐ Osteoporosis 733
- ☐ Fibromyalgia 729.1
- ☐ Other _____

Psychiatric Problems ? (check all that apply)

- ☐ Depression 311
- ☐ Anxiety 300.00
- ☐ Substance abuse __current__ recovery 304.9
- ☐ Alcohol Abuse __current__ recovery 303.9
- ☐ other _____

Neurological Problems ? (check all that apply)

- ☐ Neuropathy 356.4
- ☐ stroke 436
- ☐ TIA 435.9
- ☐ Dementia 290
- ☐ Multiple sclerosis 340
- ☐ Migraines 346
- ☐ Parkinson's disease 322
- ☐ seizure disorders 345
- ☐ Other _____

Do you have any other Medical problems ? YES NO
please list _____

Is there any other information you think may be
important _____

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Constitutional

- ☐ Recent fevers/sweats
- ☐ Unexplained weight gain
- ☐ Unexplained weight loss
- ☐ Unexplained Fatigue

Eyes

- ☐ Blurred vision
- ☐ Change in vision
- ☐ Red eyes

Ears/Nose/Throat/Mouth

- ☐ Hay fever
- ☐ Allergies
- ☐ Congestion
- ☐ Trouble swallowing
- ☐ Difficulty hearing
- ☐ Ringing in ears

Cardiovascular

- ☐ Chest pain ___ pressure
- ☐ Palpitations
- ☐ Short of breath with exertion

Respiratory

- ☐ Cough
- ☐ Wheeze
- ☐ Shortness of breath

Gastrointestinal

- ☐ Heartburn/reflux
- ☐ Blood or change in bowel movement
- ☐ Nausea/vomiting/diarrhea
- ☐ Pain in abdomen

Genitourinary

- ☐ Night time urinary frequency
- ☐ Painful/bloody urination

Trauma

- ☐ recent fall
- ☐ recent Motor vehicle crash

Musculoskeletal

- ☐ Muscle/joint swelling
where _____
- ☐ Muscle/joint pain
Where _____
- ☐ Recent back pain

Skin

- ☐ Rash
- ☐ New or change in mole
- ☐ Open wound or sore
Where _____

Neurological

- ☐ Headaches
- ☐ Memory loss
- ☐ Fainting
- ☐ Numbness in feet

Psychiatric

- ☐ Anxiety/stress
- ☐ Sleep problem
- ☐ Depression

Blood/Lymphatic

- ☐ Unexplained lumps
- ☐ Easy bruising
- ☐ bleeding

Endocrine

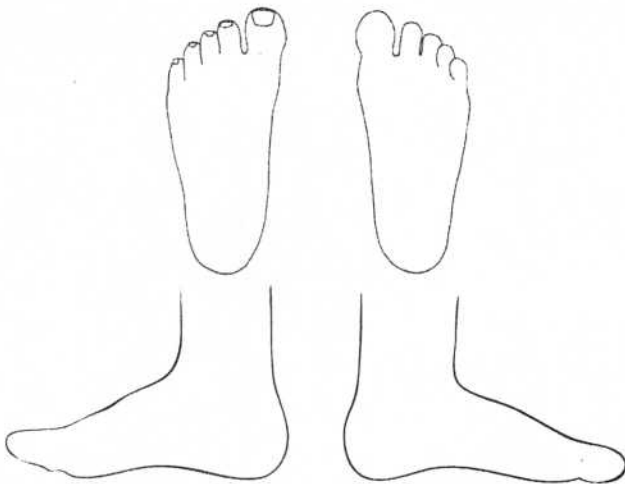
- ☐ Cold intolerance
- ☐ heat intolerance
- ☐ Increased thirst
- ☐ increased appetite
- ☐ recent high blood sugar
- ☐ low blood sugar

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

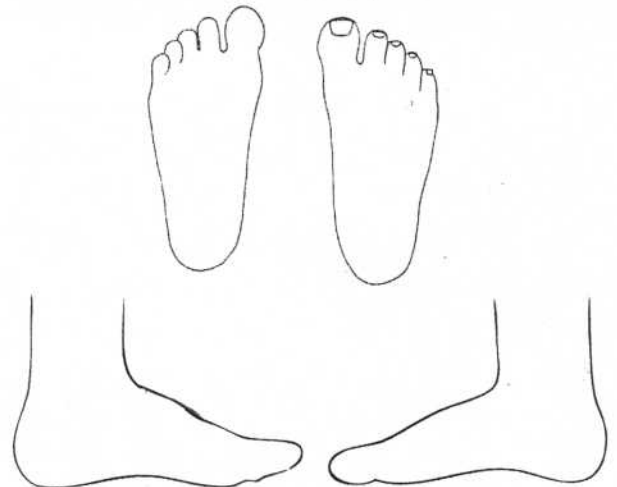
LEFT FOOT



INSIDE OF FOOT
(BIG TOE SIDE)
LEFT

OUTSIDE OF FOOT
LEFT

RIGHT FOOT



OUTSIDE OF FOOT
RIGHT

INSIDE OF FOOT
(BIG TOE SIDE)
RIGHT

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

SIGNATURE OF DOCTOR

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

DATE

SIGNATURE

DATE

ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTOOD THE NOTICE.

PATIENT NAME (PLEASE PRINT)

DATE

PARENT OR AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

SIGNATURE

Consent for Photography, Videotaping, or Other Imaging for Media or Educational Purposes

Patient's Name: _____

Patient's Date of Birth: _____

"I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand Atlantic Podiatry will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Atlantic Podiatry's policy. Images that identify me will be released and/or used outside the institution only upon additional written authorization from me or my legal representative."

I give my consent to have photographs, videotaped images, or other images made of myself or _____. I understand and agree that these images may be used by Atlantic Podiatry for the purpose outlined below.

☒ as part of my medical record and as needed for billing my insurance

☐ Teaching purposes, (Our Doctor from time to time do lectures for medical students, other physicians, nurses, and patient support groups). *

*Personally identifiable features (face or unique tattoos) will be removed or obscured no name initials etc. will be included for these purposes without additional consent.

Signature of patient/legal representative

If legal representative, relationship to patient

Date

Signature of witness

Date

CONSENT TO TREATMENT

I hereby consent to and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetic, and any and all medication or technical procedures which in the judgment of the physician(s) may be considered necessary or advisable for the diagnosing or treating of my condition.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment of insurance benefits directly to *Atlantic Podiatry Centers*. Where MEDICARE BENEFITS are applicable, I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct and request that the payment of authorized benefits be made on my behalf.

GUARANTEE OF PAYMENT

For services rendered, I guarantee payment of any and all charges incurred which are not covered or allowed by my insurance or Medicare. I also understand that I am fully responsible for any denial of payment due to lack of medical necessity or pre-certification or constraint imposed as a condition of my insurance coverage. It is further agreed that if this account be referred for collection, I will pay the costs relating to any and all collection efforts.

NON COVERED MEDICAL SUPPLIES

From time to time, your treating physician may find it necessary to recommend medical supplies to aid in the treatment of your condition. These supplies are not covered by your insurance company. Payment will be expected at the time of service. If you do not wish to purchase a recommended supply, please notify the Doctor or Nurse of your decision.

CONSENT FOR BASIC USE OF YOUR PROTECTED HEALTH INFORMATION

I hereby give my consent for Atlantic Podiatry Centers to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). This includes but is not limited to: (1) The practice may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance issues and any calls pertaining to my clinical care, including laboratory results among others. (2) The practice may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as patient statements as long as they are marked Personal and Confidential. *For a complete description of such uses and disclosures please refer to our Notice of Privacy Practices.*

By signing this form, I am consenting to Atlantic Podiatry Centers use and disclosure of PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Atlantic Podiatry Centers may decline to provide treatment to me.

** In addition to myself, details of my care may be discussed with the following family member or caretaker.

NONE

Family member/caretaker's Name Relationship

Family member/caretaker's Name Relationship

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS

/ /20

Signature of Patient or Legal Guardian Date

Printed Name of Patient or Legal Guardian

ATLANTIC PODIATRY
2209 S 25TH ST
FORT PIERCE, FL 34947

Patient Name:

Date:

Please list current medication changes:

Do you smoke? YES or NO

Did you ever get a Pneumonia shot? YES or NO (if yes approximate date)_____

Did you get a Flu shot? YES or NO (if yes approximate date)_____

Last hemoglobin A1C reading _____ (approximate date)_____

Primary Care Doctor _____ Date last seen _____

TO BE PERFORM IN ROOM

Blood Pressure _____

Biopsy _____ (date performed if needed)