Patient Acct#

DOCUFORMS™ POD-2010 • Page 1 of 2

Confidential Office Medical Record

☐ Only Changes To The Previous History Information Are Noted

☐ INITIAL HISTORY ☐ UPDATE OF HISTORY TAKEN / / / PATIENT HISTORY AS OF

1 PATIENT IDENTIFICATION AND CONTACT INFORMATION

First Name: MI: Last Name:

Your type of Job Activity / Occupation:

☐ I prefer to addressed as: Mr. Mrs. Miss Ms. Dr.

Soc. Sec. No.: Sex M / F Age Birth Date: / / Shoe Size: Weight: Height:

☐ I prefer to addressed by: ☐ First Name ☐ Nick Name

Phone Numbers For Contacting You:

Day: ( ) -

Evening: ( ) -

Cell/Pager: ( ) -

In Case of Emergency, Please Call:

Day: ( ) -

Evening: ( ) -

Please Provide Your Preferred Pharmacy:

Street / City:

Day: ( ) -

2 COMPREHENSIVE PATIENT MEDICAL HISTORY ROS/PFSH

Have you had/been treated for:

☐ Warts ☐ Corns/Calluses ☐ Leg or Foot Ulcers ☐ Broken foot bone(s) ☐ Hammer/Mallet toes ☐ Cramps in legs/feet ☐ Lower back pain ☐ Gait (Walking) problems ☐ Childhood foot problems ☐ Fungal Nails ☐ Neuroma ☐ Broken Ankle ☐ Bunions ☐ Arch pain ☐ Knee pain ☐ In-toeing ☐ Rash ☐ Athlete's Foot ☐ Ingrown nails ☐ Foot Numbness ☐ Ankle sprain ☐ Flat feet ☐ High arch feet ☐ Heel pain ☐ Toe walking ☐ ***NONE of these***

Did you previously or do you now wear:

Shoe inserts? Y N Still using them? Y N Do or did they help? Y N

Orthotics? Y N Still using them? Y N Do or did they help? Y N

The orthotics were obtained from: ☐ Another Podiatrist ☐ An Orthopedist ☐ A Physical Therapist ☐ A Chiropractor ☐ Other:

Are your first steps out of bed painful? Y N ... then subsides? Y N

Do you get leg cramps ...during the Day? Y N ...at Night? Y N

Percent of waking hours spent on your feet? 20% 40% 60% 80% 100%

List the sports/type of dance your are active in:

Does foot pain limit your desired activities? ☐ Yes ☐ No

Do you have any difficulty in walking? ☐ Yes ☐ No

Any pain in calves or buttocks when walking? ☐ Yes ☐ No

Is the pain relieved by stopping & standing still? ☐ Yes ☐ No

Do you have or have you ever been treated for:

☐ Stroke ☐ Phlebitis ☐ Diabetes ☐ Hepatitis ☐ Gout ☐ Sciatica ☐ Alzheimer's ☐ Epilepsy ☐ Glaucoma ☐ Asthma ☐ Cancer ☐ Heart Attack ☐ Vascular Disease ☐ Poor Circulation ☐ Liver Disease ☐ Arthritis ☐ Rheumatic Fever ☐ Keloid/Thick Scar ☐ Nerve Disorder ☐ Kidney Disease ☐ Lung Disease ☐ Stomach Ulcer ☐ High Blood Pressure ☐ A Heart Condition ☐ Headaches ☐ Anemia ☐ Osteoporosis ☐ Lyme's Disease ☐ Hearing/Ear Disorder ☐ Psychiatric Disorder ☐ Thyroid Problem ☐ Tuberculosis ☐ ***NONE of these***

☐ Other(s):

Do you have vascular grafts? *(If yes, explain below)* ☐ Yes ☐ No

Do you have joint implants? *(If yes, explain below)* ☐ Yes ☐ No

Do you have replacement heart valves? ☐ Yes ☐ No

Are you now under active chemotherapy? ☐ Yes ☐ No

Have you had any other serious illness? *(List below)* ☐ Yes ☐ No

Have you had any surgery? *(If yes, explain below)* ☐ Yes ☐ No

Have you ever been hospitalized or been under medical care over 24 hrs? *(If yes, explain below)* ☐ Yes ☐ No

Had Surgery for: on date of: w/ complications of:

List relationship to you of family members who have had:

Diabetes Foot Problems

Arthritis Heart Attack

Stroke High Blood Pressure

Cancer Birth Defects

# of childbirths ___ Are you currently pregnant? ☐ Yes ☐ No

Are you slow to heal after cuts? ☐ Yes ☐ No

Any abnormal bruising, bleeding or scarring? ☐ Yes ☐ No

Do you smoke now? ☐ No ☐ Yes Packs/day ___ Years___

Did you ever smoke? ☐ No ☐ Yes Packs/day ___ Years___

If you quit, when did you do so?

Alcoholic beverages? *(Circle one)* None Rarely Moderately Daily Quit

Recreational Drugs? *(Circle one)* None Rarely Moderately Daily Quit

Are you currently taking any medications? List below! ☐ Yes ☐ No

Are you taking Insulin? If yes, list below. ☐ Yes ☐ No

When noting: A = As needed, x/ = times per, D = day(s), W = week(s), M = month(s), Y = year(s)

List: Medications	Dose?	How Often?	For how long?
		A, x/ D W,	D W M Y
		A, x/ D W,	D W M Y
		A, x/ D W,	D W M Y
		A, x/ D W,	D W M Y
		A, x/ D W,	D W M Y

Are you taking your medications as prescribed? ☐ Yes ☐ No

Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:

(Check the answer box that applies)

	No	Yes	If yes, what happens?
Penicillin	☐	☐	
Other antibiotics *(list below)*	☐	☐	
Morphine	☐	☐	
Codeine	☐	☐	
Demerol	☐	☐	
Other narcotics *(list below)*	☐	☐	
Novocaine	☐	☐	
Other anesthetics *(list below)*	☐	☐	
Aspirin	☐	☐	
Empirin, Tylenol *(if yes, circle)*	☐	☐	
Advil, Aleve, or Motrin *(circle)*	☐	☐	
Other pain remedies *(list below)*	☐	☐	
Sulfa drugs	☐	☐	
Adhesive tape	☐	☐	
Shrimp, Iodine, or Merthiolate	☐	☐	
Any other drugs or medications	☐	☐	

Others:

Anything else that you want to tell the doctor? ☐ Yes ☐ No

Illnesses/Explanations:

Reason for consult:

MEDICAL INFORMATION SHEET

PLEASE PRINT CLEARLY

DATE: _____

EMRN: _____

PATIENT NAME _____ PCP (Primary Care Physician): _____

AKA (also known as): _____ D.O.B. _____

SSN#: _____ SEX: Female ☐ Male ☐ MARITAL STATUS: S ☐ M ☐ SEP ☐ D ☐ W ☐

HOME ADDRESS: _____

CITY/STATE/ZIP CODE: _____

HOME PHONE #: _____ WORK PHONE #: _____

DAYTIME/CELL PHONE #: _____ EXT #: _____

EMPLOYER NAME: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____ CITY/STATE/ZIP CODE: _____

ETHNICITY: (Select one)

☐ Hispanic/Latin/Spanish Origin
☐ NOT Hispanic/Latin/Spanish Origin
☐ Decline

RACE: (Select one)

☐ American Indian/Alaskan Native ☐ Hispanic/Latino
☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ White ☐ Decline

PREFERRED METHOD OF COMMUNICATION: (Select one) Email:

☐ Telephone ☐ Mail ☐ Decline

PERSON RESPONSIBLE FOR PATIENT'S FINANCIAL OBLIGATION, IF SELF, INDICATE SELF

NAME: _____

RELATIONSHIP: _____ SS#: _____ DOB: _____

HOME PHONE: _____ WORK PHONE #: _____ EXT: _____

DAYTIME/CELL PHONE #: _____ EXT: _____

HOME ADDRESS (If different from Patient's address): _____

CITY/STATE/ZIP CODE: _____

EMPLOYER NAME: _____ CITY/STATE/ZIP CODE: _____

IN CASE OF EMERGENCY - NAME OF RELATIVE NOT LIVING WITH YOU (Local)

PRIMARY CONTACT NAME: _____ RELATIONSHIP: _____

HOME PHONE #: _____ WORK PHONE #: _____ EXT: _____

DAYTIME/CELL PHONE #: _____ EXT: _____

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

SECONDARY CONTACT NAME: _____ RELATIONSHIP: _____

HOME PHONE #: _____ WORK PHONE #: _____ EXT: _____

DAYTIME/CELL PHONE #: _____ EXT: _____

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

PATIENT INSURANCE INFORMATION DO YOU HAVE HEALTH INSURANCE? YES ☐ NO ☐

PRIMARY INSURANCE

INSURANCE CO: _____

INSURANCE PHONE #: _____

SUBSCRIBER: _____

SUBSCRIBER'S EMPLOYER NAME: _____

SUBSCRIBER'S DATE OF BIRTH: _____

SUBSCRIBER'S SSN #: _____

POLICY # _____

GROUP # _____

EFFECTIVE DATE: _____

SECONDARY INSURANCE

INSURANCE CO: _____

INSURANCE PHONE #: _____

SUBSCRIBER: _____

SUBSCRIBER'S EMPLOYER NAME: _____

SUBSCRIBER'S DATE OF BIRTH: _____

SUBSCRIBER'S SSN #: _____

POLICY #: _____

GROUP #: _____

EFFECTIVE DATE: _____

ASSIGNMENT OF BENEFITS

I hereby authorize and direct my insurance company to make payments to Felix Sigal DPM benefits allowable and otherwise payable to me and/or my dependents. I understand that I am responsible for charges not paid under this Assignment. This Authorization will remain in effect until rescinded by myself in writing. A photocopy of this Assignment may be honored.

PATIENT'S SIGNATURE: _____ DATE: _____

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

Appointment Cancellation Policy

Because we are a small clinic an there is a high demand for our services. we must enforce a strict cancellation and no-show policy.

We kindly ask you to call us 24 hours in advance should you need to cancel or reschedule your doctor's appointment. If you do not show for your appointment without giving us advanced notice. you will be charges a **$ 75.00 No-Show Charge. This will not be billed to your insurance carrier.**

Please sign below indicating you understand your responsibility when scheduling appointment with our Clinic.

Póliza Para Cancelación De Cita

Por razón que nuestra oficina es pequeña y hay una alta demanda para nuestros servicios. tenemos que en forzar un póliza estricta para cancelaciones y citas no asistidas.

Pedimos su consideración en llamar 24 horas antes de su cita si necesita cancelar o re-hacer su cita. Si usted no puede atender a su cita y no nos da notificación va a tener un cobro de **$75.00. Esto no es cubierto por su aseguranza de salud.**

Por favor firme abajo indicando que entiende su responsabilidad cuando hace citas en nuestra clínica.

PATIENT NAME/ NOMBRE DEL PACIENTE _____

PATIENT SIGNATURE/ FIRMA DEL PACIENTE _____

DATE/FECHA _____

Revised 3/30/2016