Patient:_____

First Name *M.I.* *Last Name*

PLEASE FILL OUT THE INFORMATION AS DETAILED & LEGIBLE AS POSSIBLE. THANK YOU.

Height: _____**feet** _____**inches or** _____ **cm Weight:** _____**lbs / kg** ***Shoe size & Width***: _____

Occupation: _____**Former Occupation:** _____ **Gender M F** _____

Date of Birth:_____**Age**_____**Social Security #:**_____

Address_____

City: _____**State**_____**Zip**_____

Home Phone:_____**Work Phone:**_____**Cell Phone:**_____

Emergency Contact: _____ **Phone/Cell Phone:** _____

E-Mail Address: _____

Primary Care Physician:_____**Phone:**_____

Cardiologist: _____**Endocrinologist:** _____

Nephrologist: _____**Rheumatologist:** _____

PLEASE PROVIDE YOUR INSURANCE CARDS AND PHOTO ID (DRIVER'S LICENSE) TO THE FRONT OFFICE MANAGER.

Primary Insurance Company: _____

Policy Holder's Name _____ Policy Holder's Date of Birth: _____

Policy Holder's Member's ID Number and Social Security_____

Secondary Insurance Company: _____

Policy Holder's Name _____ Policy Holder's Date of Birth: _____

Policy Holder's Social Security Number_____

HOW DID YOU FIND US?

Friend / Relative Referal_____

Internet: Google Yahoo Yelp Friends of Fallbrook Fallbrook Yellow Pages Banners

Other_____

First Name *M.I.* *Last Name*

Are you pregnant? (circle one) YES NO if YES → How many months? _____(CONGRATULATIONS!)

HISTORY OF CURRENT FOOT / ANKLE PROBLEM (CHECK ALL THAT APPLY):

○ Ingrown Nails	○ Heel Pain	○ Bunions
○ Nail Fungus	○ Joint Pain / Stiffness	○ Hammertoes
○ Warts	○ Leg/Ankle Swelling	○ Flat Feet
○ Gout	○ Athletes foot	○ You think your feet are ugly

TRAUMA/OTHER _____

_____

_____

Which side: Right, Left, Both? Which toe: _____

How long has the problem been present? _____ days / weeks / month / years

Have you had any treatment or taken anything for it? _____

_____

Have you seen someone for this already? No Yes Whom? _____

Please MARK, LIST, and or circle all ALLERGIES: Foods:_____Tapes_____

Aspirin Lidocaine Novocain Penicillin Cipro Iodine Codeine Vicodin Sulfa Drugs
Shellfish Shrimp Citrus Hay Fever Tape Adhesive Latex

Other: What types of other reactions/sensitivities have you experienced? _____

_____

Please list all MEDICATIONS and the dosages:

(if you have a list, please hand it to the front office manager to copy; no need to fill it out)

1. _____ **5.** _____

2. _____ **6.** _____

3. _____ **7.** _____

4. _____ **8.** _____

9. _____ **10.** _____

PREFERRED PHARMACY:_____ **PHONE#:**_____

First Name *M.I.* *Last Name*

PERSONAL MEDICAL HISTORY:

****CHECK / CIRCLE THOSE THAT APPLY TO YOU NOW OR HAVE APPLIED TO YOU IN THE PAST****

	Anemia/Blood Disorders/ Bleeding Disorders		HIV
	Arthritis		High Blood Pressure
	Asthma / Hay Fever / Shortness of Breath		High Cholesterol
	Blood Clots		Kidney Disease (stones, infection)
	Chest Pain on Mild Exertion		Liver Disorder (Cirrhosis, Hepatitis)
	Cerebral Palsy or Polio		Pneumonia
	Diabetes X _____ years Average Blood Sugar = _____ HBA1C = _____		
	Dialysis M W F or T TH SA		Prolonged Bleeding Time
	Drug/Alcohol Abuse		Prostate Disorder
	Ear, Nose, Throat Disorder		Psychiatric Treatment
	Emotional Problems/Tension		Rheumatic / Scarlet fever
	SKIN problems: dry psoriasis dermatitis		Sexually Transmitted Disease / Syphilis / Gonorrhea
	Emphysema		Stomach/Ulcer Disorder
	Epilepsy or Seizures		Stroke
	Eye (cataracts , glaucoma)		Tuberculosis
	Gout		Thyroid/Parathyroid Disease
	Headaches/Migraines		Tumor/Abnormal Growth/Cancer
	Heart problems		Other

SURGICAL HISTORY

Surgical Procedures/Serious Injuries/Illnesses	Year	Physician	Hospital

FAMILY HUSTORY – PLEASE CHECK (X) ANY FAMILY MEDICAL HISTORY

	Cancer	Heart	Stroke	Blood Pressure	Blood Clots	Kidney	Diabetes	Mental	Emphysema
Maternal	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal	☐	☐	☐	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

Do you Smoke Currently? ☐ YES ☐ NO How Many Years? _____ Packs/Day?_____

Did You Smoke Previously? ☐ YES ☐ NO When Did You Quit?_____ How Many Years? _____ Packs/Day?_____

Number of caffeine drinks per DAY? _____ Amount of alcohol consumed per WEEK _____

Any illicit drugs? _____ Current User? Former User?

Marijuana Smoking / Vaping _____

PLEASE CIRCLE/CHECK OFF ALL THAT *CURRENTLY* APPLY TO YOU

CONSTITUTIONAL: ☐ APPETITE DECREASE, ☐ APPETITE INCREASE, ☐ CHILLS, ☐ CONVULSIONS/SEIZURES, ☐ FEVER, ☐ MALAISE, ☐ NIGHT SWEATS, ☐ SLEEP PROBLEMS, ☐ WEIGHT GAIN, ☐ WEIGHT LOSS.

CARDIOLOGICAL: ☐ ANKLE SWELLING, ☐ CALF CRAMPING, ☐ CHEST PAIN, ☐ HEART PALPITATIONS, ☐ JAW PAIN, ☐ HEART MURMUR, ☐ PACEMAKER, ☐ SHORTNESS OF BREATH.

ENDOCRINE: ☐ COLD INTOLERANCE, ☐ DRY HAIR, ☐ DRY SKIN, ☐ EXTREME THIRST, ☐ HEAT INTOLERANCE, ☐ HOT FLASHES, ☐ HYPERGLYCEMIA, ☐ RECENT HAIR LOSS, ☐ UNUSUAL FATIGUE.

ENT (EAR, NOSE, THROAT): ☐ CHRONIC COUGH, ☐ DIFFICULTY WITH HEARING, ☐ DIFFICULTY WITH SWALLOWING, ☐ LOSS OF SENSE OF SMELL, ☐ POST-NASAL DRIP, ☐ RECENT NOSEBLEED, ☐ RINGING IN EARS (TINNITUS), ☐ SINUS PROBLEMS, ☐ SORE THROAT, ☐ SWOLLEN OR PAINFUL NECK GLANDS.

EYES: ☐ BIFOCALS, ☐ BLURRED VISION, ☐ DOUBLE VISION, ☐ FARSIGHTEDNESS, ☐ LOSS OF VISION, ☐ NEARSIGHTEDNESS, ☐ PHOTOSENSITIVITY.

GASTROINTESTINAL: ☐ ABDOMINAL PAIN, ☐ BLOOD IN STOOL, ☐ CONSTIPATION, ☐ DIARRHEA, ☐ GASTRIC REFLUX/HEARTBURN, ☐ NAUSEA.

GENITOURINARY: ☐ BLADDER SPASM, ☐ BLOOD IN URINE, ☐ BURNING WITH URINATION, ☐ URINARY TRACT INFECTION, ☐ KIDNEY PROBLEMS OR DISORDERS, ☐ OVARIAN CYSTS, ☐ PROSTATE PROBLEMS, ☐ URINARY FREQUENCY, ☐ URINARY URGENCY, ☐ UTERINE FIBROIDS.

IMMUNOLOGIC: ☐ ARTHRITIC FLARE-UP, ☐ RECENT ASTHMA ATTACK, ☐ SNEEZING, ☐ ENVIRONMENTAL ALLERGIES, ☐ EYES WATERING, ☐ SEASONAL ALLERGIES.

INTEGUMENTARY (SKIN): ☐ BURNING OF THE SKIN, ☐ DANDRUFF, ☐ DERMATITIS, ☐ ECZEMA, ☐ EXCESSIVE SCAR TISSUE, ☐ HYPERSENSITIVITY OR SKIN RASH, ☐ NON-HEALING WOUNDS, ☐ PSORIATIC FLARE-UP, ☐ TINGLING SENSATION.

LYMPHATIC: ☐ ANEMIA, ☐ ANKLE EDEMA, ☐ BLEEDING TENDENCY, ☐ BRUISE EASILY, ☐ LEG SWELLING, ☐ RECENT SICKLE CELL CRISIS, ☐ RECENT TRANSFUSION, ☐ SWOLLEN GROIN LYMPH NODES, ☐ SWOLLEN NECK LYMPH NODES, ☐ SWOLLEN UNDERARM LYMPH NODES.

MUSCULOSKELETAL: ☐ BACK PAIN, ☐ JOINT PAIN, ☐ JOINT REDNESS, ☐ JOINT SWELLING, ☐ LEG CRAMPS, ☐ MORNING STIFFNESS, ☐ MUSCLE TENDERNESS, ☐ NECK PAIN, ☐ STIFFNESS, ☐ WEAKNESS OF MUSCLES, ☐ DIFFICULTY WITH WALKING.

NEUROLOGICAL: ☐ BURNING OF TOES OR FINGERS, ☐ HYPERSENSITIVITY, ☐ NEUROLOGICAL PROBLEMS, ☐ NUMBNESS, ☐ TREMORS, ☐ PARALYSIS, ☐ RECENT SEIZURE, ☐ STOCKING/GLOVE NUMBNESS, ☐ TINGLING OF TOES OR FINGERS, ☐ UNCONTROLLED MOVEMENTS.

PSYCHIATRIC: ☐ ADDICTIVE TENDENCIES, ☐ ANGER ISSUES, ☐ ANXIOUSNESS, ☐ ATTEMPTED SUICIDE, ☐ CLAUSTROPHOBIA, ☐ CONSTANT OVEREATING, ☐ DEPRESSION, ☐ DISORIENTATION, ☐ IRRITABILITY, ☐ LIBIDO DECREASE, ☐ MEMORY LOSS, ☐ MENTAL STATUS CHANGES, ☐ PANIC ATTACKS, ☐ PARANOIA, ☐ POOR SLEEP PATTERN, ☐ SUICIDAL THOUGHTS.

RESPIRATORY: ☐ BREATHING DIFFICULTIES, ☐ RESPIRATORY SYMPTOMS, ☐ CHEST PAIN WITH INSPIRATION, ☐ WHEEZING, ☐ SNORING, ☐ RECENT ASTHMA ATTACK, ☐ RECENT EXPOSURE TO TUBERCULOSIS, ☐ SHORTNESS OF BREATH, ☐ SLEEP APNEA.

❼ SIGNATURES

❶ I hereby authorize direct payment of surgical and medical benefits on my behalf to the provider of these services that would otherwise be payable to me if I did not make this assignment. I understand that I am personally responsible to the physician for charges not covered by my insurance agreement. I also understand that if my account becomes delinquent, I will be responsible for any costs of collection of my account, including collection fees and attorney costs. A $50.00 per month re-invoicing fee will apply to all accounts ten days past due. I permit a copy of this assignment to be used instead of the original for billing purposes.
The information I provided is accurate to the best of my knowledge. I authorize either physician or hospital to release any previous medical records by fax, mail, or phone. Also, I authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition using X-ray examination or photographs as necessary.
I give Fallbrook Podiatry INC (Dr. Grigoriy N. Patish, D.P.M & Dr. Frank J. Witt, DPM) permission to obtain and release medical information to insurance companies and referring physicians. I have read the previous information and agree with Fallbrook Podiatry INC (Dr. Grigoriy N. Patish, D.P.M & Dr Frank J. Witt, DPM) office policy.

SIGNATURE: _____**Date:** _____/_____/_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN
**If not patient, relationship to patient: ☐ Parent ☐ Power of attorney ☐ Legal Guardian ☐ Other: _____

❷ HMO INSURANCE (IF YOU DO NOT HAVE AN HMO, **PLEASE INITIAL**, NO FULL SIGNATURE REQUIRED)

All HMO patients must have a referral/authorization before each (all) office visit. Failure to have a referral will result in the patient being billed for all services rendered.

SIGNATURE: _____**Date:** _____/_____/_____

❸ CANCELLATIONS AND MISSED APPOINTMENTS

24-hour notice is required for canceled appointments. -

Patients will be assessed a $195 charge for a missed appointment or less than 24-hour notice.

SIGNATURE: _____**Date:** _____/_____/_____

❹ PRIVACY INFORMATION

CHECK ALL THAT APPLY

May we leave appointment and medical information by way of message or email:

Patient Only?	Y	N	Patient and/or Spouse?	Y	N
Anyone answering home phone?	Y	N	On Home Voice Mail?	Y	N
Via E-Mail?	Y	N	On Cell Voice Mail?	Y	N

Other instructions on medical information handling_____

First Name *MI* *Last Name*

SIGNATURE: _____**Date:** _____/_____/_____

❺ RELEASE OF INFORMATION

By my signature, I authorize the practice of FALLBROOK PODIATRY INC, Dr. Frank J. Witt & Dr. Grigoriy N. Patish to disclose, when requested by all named insurance carriers or their representatives, any information concerning any illness(es) or injury(ies), medical history or treatment and copies of all medical records. I additionally authorize, if applicable, payment directly to the practice of FALLBROOK PODIATRY INC, Dr. Frank J. Witt & Dr. Grigoriy N. Patish of any surgical and/or medical benefits, otherwise payable to me for professional services rendered to me. I understand that I am financially responsible for the charges not covered by this authorization. In the event of nonpayment, I further agree to bear the cost or reasonable legal fees should this be required. A photostatic copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE: _____**Date:** _____/_____/_____

❻ ***ACKNOWLEDGEMENT OF RECEIPTS OF NOTICE OF PRIVACY PRACTICES***

I acknowledge that I have read or had the opportunity to read the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and understood the Notice.

SIGNATURE: _____**Date:** _____/_____/_____

** If you have yet to have the opportunity to review the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a copy is available in our office for you to review and take home.

❼ **CONSENT FOR: TREATMENT • OBSERVATION • PHOTO • TISSUE SAMPLING • TISSUE STUDY**

ANY ALTERATIONS TO THIS CONSENT FORM WILL RESULT IN THE REFUSAL OF SERVICE

I hereby consent to examination and treatment as indicated by my consultation with FALLBROOK PODIATRY INC, Dr. Frank J. Witt, and Dr. Grigoriy N. Patish. I further understand that the use of any anesthetics, sedatives, x-rays, or surgeries, as may be deemed necessary by FALLBROOK PODIATRY INC, Dr. Frank J. Witt, and Dr. Grigoriy N. Patish, will not be done without discussion with the Doctor.

I further consent to and authorize the performance of any other surgical and non-surgical procedures or treatment determined by the doctor during such operation to be advisable to achieve the intended surgical goal or to protect my health and well-being. I acknowledge that no guarantee or assurance has been made about the results that may be obtained. I consent to the administration of anesthesia and to the use of such anesthetics as the doctor may deem advisable. I consent to administering radiologic procedures (x-rays), taking tissue samples for laboratory testing, and such additional services or testing as necessary. I consent to disposing of any tissues or parts that may be removed during the surgical procedure. I understand that the use and abuse of drugs, prescribed or otherwise, alcohol, tobacco (both past and present), or the existence of conditions such as allergies to medications, pregnancy, epilepsy, herpes, hepatitis, AIDS, and others, not disclosed to the doctor may put me in greater risk of surgical complications. I ASSUME ALL RISKS that may exist due to my failure or refusal to disclose such matters before treatment. I further understand that systemic conditions, including but not limited to diabetes, rheumatoid arthritis, peripheral vascular disease, and autoimmune disorders, may put me at a higher risk for complications from undergoing surgical procedures.

For advanced podiatric medical education, I consent to the admittance of observers to the operating/procedure room and the photographing/video recording of the surgical procedure(s)

SIGNATURE: _____**Date:** _____/_____/_____

YOU MADE IT. YOU ARE AWESOME.