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: _____

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_____
Please Provide your insurance cards and photo ID (driver's license) to the front office manager

HOW DID YOU FIND US?

Friend / Relative Referal_____

Internet: Google Yahoo Yelp SoftToes.com Friends of Fallbrook Fallbrook Yellow Pages

Riverside Yellow Book Other_____

Patient:_____

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

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

HISTORY OF PRESENT 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? _____

Pease 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 front office manager to copy, no need to fill out)

1._____ **5.**_____

2._____ **6.**_____

3._____ **7.**_____

4._____ **8.**_____

9._____ **10.**_____

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

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

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 _____

Illicit Drugs? YES NO _____

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

REVIEW OF SYSTEMS **Please CIRCLE all that ***currently*** apply to you**

Constitutional: appetite decrease appetite increase chills convulsions/seizures fever malaise night sweats sleep problems weight gain weight loss, unintentional

Cardio/Resp: ankle swelling calf cramping chest pain heart palpitations jaw pain pace maker shortness of breath murmur

Endocrine: cold intolerance dry hair dry skin extreme thirst heat intolerance hot flashes hyperglycemia recent hair loss unusual fatigue

ENT: cough, chronic difficulty with hearing difficulty with swallowing lost sense of smell post-nasal drip recent nose bleed ringing in ears sinus problems sore throat swollen or painful neck glands tinnitus

Eyes: bifocals blurred vision double vision farsighted loss of vision near sighted photosensitivity

Gastro/Intestinal: abdomen pain blood in stool constipation diarrhea heartburn nausea

Genito-Urinary: bladder spasm blood in urine burning with urination urinary tract infection kidney problems or disorder ovarian cysts prostate problems urinary urgency uterine fibroids urinary frequency

Immunologic: arthritic flare-up asthma attack recently environmental allergies eyes watering seasonal allergies sneezing

Integumentary: burning of skin dandruff dermatitis eczema excessive scar tissue rash hypersensitivity of 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

Muscular: back pain joint pain joint redness joint swelling leg cramps morning stiffness

Skeletal: muscle tenderness neck pain stiffness weakness of muscles difficulty with walking

Neurological: burning of toes or fingers hypersensitivity neurological problems numbness paralysis recent seizure stocking / glove numbness tingling of toes or fingers uncontrolled tremors movements

Psychiatric: addictive tendencies anger issues anxiousness attempted suicide memory loss constant over eating depression disorientation irritability libido decrease claustrophobia mental status changes panic attacks paranoia poor sleep pattern suicidal thoughts

Respiratory: breathing difficulties chest pain with inspiration wheezing snoring recent asthma attacks 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 I 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 $5.00 per month re-invoicing fee will apply to all accounts 10 days past due. I permit a copy of this assignment to be used in place of the original for purposes of billing.
The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital generated. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition, to use 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 understand and agree to 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 visits. 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 cancelled appointments.

Patients will be assessed a $95 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_____

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 and all information with respect to 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. I further agree, in the event of nonpayment, to bear the cost or reasonable legal fees should this be required. A photo static 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 that I understood the Notice.

Signature: _____ Date: _____/_____/_____

** If you have not had the opportunity review the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a copy is available in our office for your review and take home.

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

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

I hereby consent to examination and treatment as indicated by my consultation with FALLBROOK PODIATRY INC, Dr. Frank J. Witt & 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 & 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 as well as non-surgical procedures or treatment determined by the doctor during the course of 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 the administration of radiologic procedures (x-rays), the taking tissue samples for laboratory testing and such additional services or testing as may be necessary. I consent to the disposal of any tissues or parts which 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 and I ASSUME ALL RISKS which may exist as a result of my failure or refusal to disclose such matters prior to 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 the purpose of advanced podiatric medical education, I consent for the admittance of observers to the operating/procedure room and to the photographing/video taping of the surgical procedure(s)

Signature: _____ Date: _____/_____/_____

YOU MADE IT. YOU ARE AWESOME.