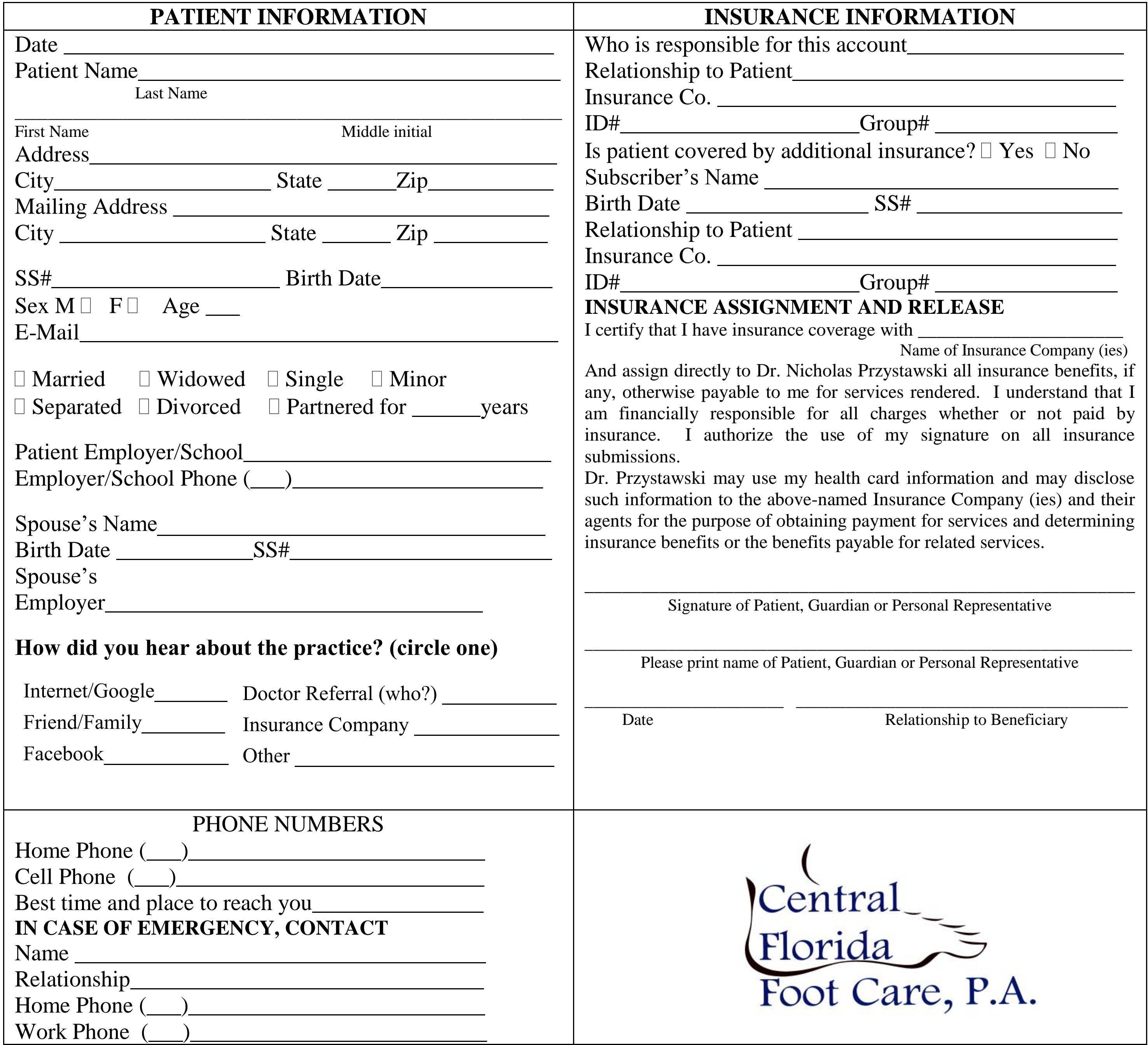
Central Florida Foot Care, P.A.

WELCOME



PATIENT INFORMATION	INSURANCE INFORMATION
Date ______________________________	Who is responsible for this account____________________
Patient Name______________________________ Last Name	Relationship to Patient______________________________
______________________________ First Name Middle initial	Insurance Co. ______________________________
Address______________________________	ID#____________________Group# ______________
City__________________ State ______Zip___________	Is patient covered by additional insurance? ☐ Yes ☐ No
Mailing Address ______________________________	Subscriber's Name ______________________________
City __________________ State ______ Zip __________	Birth Date ________________ SS# __________________
SS#____________________ Birth Date_______________	Relationship to Patient ____________________________
Sex M ☐ F ☐ Age ___	Insurance Co. ______________________________
E-Mail______________________________	ID#____________________Group# ______________
☐ Married ☐ Widowed ☐ Single ☐ Minor	**INSURANCE ASSIGNMENT AND RELEASE**
☐ Separated ☐ Divorced ☐ Partnered for ______years	I certify that I have insurance coverage with ____________________ Name of Insurance Company (ies)
Patient Employer/School___________________________	And assign directly to Dr. Nicholas Przystawski all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
Employer/School Phone (___)______________________	Dr. Przystawski may use my health card information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.
Spouse's Name______________________________	
Birth Date ____________SS#______________________	______________________________ Signature of Patient, Guardian or Personal Representative
Spouse's Employer______________________________	______________________________ Please print name of Patient, Guardian or Personal Representative
How did you hear about the practice? (circle one)	__________________ ____________________________ Date Relationship to Beneficiary
Internet/Google_______ Doctor Referral (who?) __________	
Friend/Family________ Insurance Company _____________	
Facebook____________ Other ______________________	

PHONE NUMBERS	
Home Phone (___)__________________________	Central Florida Foot Care, P.A.
Cell Phone (___)__________________________	
Best time and place to reach you_______________	
IN CASE OF EMERGENCY, CONTACT	
Name ______________________________	
Relationship______________________________	
Home Phone (___)__________________________	
Work Phone (___)__________________________	

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)	Is there any personal or family history of diabetes?	Please indicate which foot problems you now have or have had in the past.
______________________________	☐ Yes ☐ No	Ankle Pain ☐Yes ☐No
______________________________	Your occupation____________________	Athlete's Foot ☐Yes ☐No
______________________________	Cigarette/Tobacco use_______________	Bunions ☐Yes ☐No
Have you ever been to a Podiatrist before?	Years Smoked______________________	Corns and Calluses ☐Yes ☐No
☐ Yes ☐ No	Athletic activities in which you participate (please list and indicate frequency)	Cramps or Numbness in Feet or Legs ☐Yes ☐No
If yes, please list.	______________________________	Flat Feet ☐Yes ☐No
Name______________________________	______________________________	Foot or Leg Cramps ☐Yes ☐No
Last Visit__________________________	______________________________	Heel Pain ☐Yes ☐No
		Ingrown Toenails ☐Yes ☐No
		Plantar Warts ☐Yes ☐No
		Swelling in Ankles or Feet ☐Yes ☐No
		Tired Feet ☐Yes ☐No

Please **CIRCLE** to indicate if you have had any of the following:

AIDS/HIV	Chest Pain	Hemophilia	Rheumatic Fever
Allergies to Anesthetics	Chronic Diarrhea	Hepatitis or Jaundice	Shortness of Breath
Allergies to Medicine or Drugs	Circulatory Problems	High Blood Pressure	Sinus Problems
Anemia	Diabetes	Kidney Problems	Special Diet
Angina	Ear Problems	Liver Disease	Stroke
Arthritis	Epilepsy	Low Blood Pressure	Swelling in Ankles, Feet
Artificial Heart Valves or Joints	Eye Problems	Neuropathy	Swollen Neck Glands
Asthma	Fainting	Phlebitis	Tired Feet
Back Problems	Foot or Leg Cramps	Psychiatric Care	Tuberculosis
Bleeding Disorders	Gout	Radiation Treatment	Ulcers
Cancer	Headaches	Rash	Varicose Veins
Chemical Dependency	Heart Disease	Respiratory Disease	Weight Loss, unexplained

Surgeries you have had ____

____

____

Hospitalization other than for the surgeries listed ______________________________

____

____

Family Physician______________________________ **Date of last visit** ______________

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain ____

____

____

MEDICATIONS	ALLERGIES	
Include prescriptions, over-the-counter medications and vitamins	☐Adhesive/Tape	☐ Local Anesthetic
______________________________	☐Novocain	☐ Aspirin
______________________________	☐Penicillin	☐ Codeine
______________________________	☐Seafood	☐ Demerol
______________________________	☐Sulfa	☐ Iodine
Pharmacy Name(s)______________________	☐Anticoagulant Therapy	
Pharmacy Phone(s) (___)______________________	Other ______________	
Do you take oral contraceptives? ☐Yes ☐No		

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me, as the doctor deems necessary.

______________________________ ______________

Signature of Patient, Parent, Guardian or Personal Representative — Date

______________________________ ______________

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient