



# WELCOME

PATIENT INFORMATION	INSURANCE INFORMATION
Date _____ Patient Name _____ <div style="text-align: right; margin-right: 100px;">Last Name</div> <hr/> First Name _____ Middle initial _____ Address _____ City _____ State _____ Zip _____ Mailing Address _____ City _____ State _____ Zip _____ SS# _____ E-Mail _____ Sex M <input type="checkbox"/> F <input type="checkbox"/> Age ____ Birth Date _____ <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered for _____ years Patient Employer/School _____ Employer/School Phone (____) _____ Spouse's Name _____ Birth Date _____ SS# _____ Spouse's Employer _____	Who is responsible for this account _____ Relationship to Patient _____ Insurance Co. _____ Group # _____ Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Subscriber's Name _____ Birth Date _____ SS# _____ Relationship to Patient _____ Insurance Co. _____ Group # _____ <b>INSURANCE ASSIGNMENT AND RELEASE</b> I certify that I have insurance coverage with _____ <div style="text-align: right; margin-right: 100px;">Name of Insurance Company(ies)</div> 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. 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.
<b>How did you hear about us?</b> _____ _____ _____	_____ <div style="text-align: center;">Signature of Patient, Guardian or Personal Representative</div> _____ <div style="text-align: center;">Please print name of Patient, Guardian or Personal Representative</div> _____ Date _____ Relationship to Beneficiary _____
<div style="text-align: center;"><b>PHONE NUMBERS</b></div> Home Phone (____) _____ Cell Phone (____) _____ Best time and place to reach you _____ <b>IN CASE OF EMERGENCY, CONTACT</b> 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.) _____ _____ _____ Have you ever been to a Podiatrist before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list. Name _____ Last Visit _____	Is there an personal or family history of diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No Your occupation _____ Cigarette/Tobacco use _____ Years Smoked _____ Athletic activities in which you participate (please list and indicate frequency) _____ _____ _____	Please indicate which foot problems you now have or have had in the past. <table style="width:100%; border: none;"> <tr> <td>Ankle Pain</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Athlete's Foot</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Bunions</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Corns and Calluses</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Cramps or Numbness in Feet or Legs</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Flat Feet</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Foot or Leg Cramps</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Heel Pain</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Ingrown Toenails</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Plantar Warts</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Swelling in Ankles or Feet</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Tired Feet</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>	Ankle Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Athlete's Foot	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bunions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Corns and Calluses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cramps or Numbness in Feet or Legs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Flat Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foot or Leg Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heel Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ingrown Toenails	<input type="checkbox"/> Yes <input type="checkbox"/> No	Plantar Warts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling in Ankles or Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tired Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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	<input type="checkbox"/> Adhesive/Tape <input type="checkbox"/> Local Anesthetic
_____	<input type="checkbox"/> Novocain <input type="checkbox"/> Aspirin
_____	<input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine
_____	<input type="checkbox"/> Seafood <input type="checkbox"/> Demerol
Pharmacy Name(s) _____	<input type="checkbox"/> Sulfa <input type="checkbox"/> Iodine
Pharmacy Phone(s) (____) _____	<input type="checkbox"/> Anticoagulant Therapy
Do you take oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____

### 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

305 Childs Street  
Leesburg, FL 34748



Phone: 352-360-1360  
Fax: 352-360-0686