Welcome to Rochester Podiatry LLP

PATIENT INFORMATION

Date of Appointment _____
Patient Last Name _____
First Name _____ Middle Initial _____
Address _____
City _____
State _____ Zip _____
E-Mail _____
Sex ___M ___ F Age _____ Birthdate _____
___Married ___ Widowed ___ Single ___ Minor
___ Separated ___ Divorced ___ Partnered
Occupation _____
Patient Employer/School _____
Employer/School Address _____
Spouse/Partner's Name _____
Spouse/Partner Birthdate _____
Spouse/Partner Employer _____
Whom may we thank for referring you? _____
Referrer Relationship to patient? _____
How did you hear about our office:
___ Insurance List ___ Internet
___ Phone Book ___ Other _____

PHONE NUMBERS

Home Phone ( ) _____
Cell Phone ( ) _____
Work Phone ( ) _____
Best time and place to reach you: _____
In Case of Emergency, Contact: _____
Relationship to patient: _____
Home Phone ( ) _____
Cell Phone ( ) _____
Work Phone ( ) _____

INSURANCE

Insurance Assignment and Release

I certify that I have insurance coverage with my insurance company (ies) and assign directly to Massimo Pietrantoni DPM and Rochester Podiatry 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. Rochester Podiatry may use my health care 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 of the benefits payable for related services.

_____
Signature of Patient or Guardian

_____
Please Print name of Patient or Guardian Date

PATIENT HISTORY

Reason for Visit today:
_____
_____
_____

Primary Physician:
_____

Date of Last Visit: _____
Address:
_____
_____

Phone #: _____

Your Primary Physician's Hospital Affiliation:
_____

Do you need Antibiotics before Surgery/Dental Procedures? Yes No

Surgeries : ____ **NONE**

_____ YR.
_____ YR.
_____ YR.
_____ YR.
_____ YR.
_____ YR.
_____ YR.

Pharmacy: _____
Phone #: _____
Address: _____
_____

Medications & Dosage:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies: ____ **NONE**

___ Adhesive/ tape
___ Anticoagulant therapy
___ Asprin
___ Codeine
___ Demerol
___ Iodine
___ Latex
___ Local Anesthetics
___ Penicillin
___ Metal/Nickel
___ Seafoods
___ Sulfa
___ Other _____
_____
_____
_____

PATIENT HISTORY- CONTINUED

Height _____ Weight _____
Shoe Size _____
Have you seen a Podiatrist in the past?
_____ Yes _____ No
If Yes, Please List:
Name _____
Last Visit _____
Reason _____
_____

Social History:

Tobacco	___ Yes	___ No
Alcohol	___ Yes	___ No
Coffee/tea	___ Yes	___ No
Recreational drugs	___ Yes	___ No
I.V. Drugs	___ Yes	___ No

Family History: M= Mother F= Father

Heart Disease	___ Yes	___ No
Stroke	___ Yes	___ No
Diabetes	___ Yes	___ No
Gout	___ Yes	___ No
Cancer	___ Yes	___ No
Sickle Cell	___ Yes	___ No
Flatfoot	___ Yes	___ No
Psoriasis	___ Yes	___ No
Rheumatoid Arthritis	___ Yes	___ No

PODIATRIC HISTORY

Current (C), Past (P), N/A: Please indicate which applies to you currently or you had in the past

	C	P	N/A
Ankle Pain	___	___	___
Athlete's Foot	___	___	___
Bunions	___	___	___
Corns, Calluses or lesions	___	___	___
Numbness feet/legs	___	___	___
Flat feet	___	___	___
Use over the counter inserts	___	___	___
Use Orthotics	___	___	___
Heel Pain	___	___	___
Ingrown toenails	___	___	___
Plantar warts	___	___	___
Foot Ulcers	___	___	___

MEDICAL HISTORY

	Yes	No
AIDS/HIV	___	___
Anemia	___	___
Type _____		
Angina	___	___
Arthritis	___	___
Type_____		
Artificial heart valves	___	___
Asthma	___	___
Back Problems	___	___
Bleeding Disorders	___	___
Cancer	___	___
Chemical Dependency	___	___
Chest Pain	___	___
Cholesterol	___	___
Circulatory Problems (PVD)	___	___
Diabetes	___	___
Type _____		
_____ Use Insulin		
_____ Use Pills		
Ear Problems	___	___
Eye Problems	___	___
Gout	___	___
Heart Disease	___	___
Hepatitis	___	___
Type _____ What Year _____		
Jaundice	___	___
High Blood Pressure	___	___
Implants	___	___
Type _____		
Kidney Problems	___	___
Liver Disease	___	___
Low Blood Pressure	___	___
Low Back Disc/Nerve Injury	___	___
M.S. (Multiple Sclerosis)	___	___
Neuropathy/Numbness	___	___
Phlebitis	___	___
Prior Blood Clots/DVT	___	___
Psoriasis	___	___
Psychiatric Care	___	___
Rash/Dermatitis	___	___
Respiratory /Lung Disease	___	___
Rheumatoid Arthritis	___	___
Scleroderma	___	___
Sinus Problems	___	___
Special Diet	___	___
Stroke	___	___
Swollen Neck Glands	___	___
Thyroid Disease	___	___
Tuberculosis (TB)	___	___
Ulcers (Stomach/G.I)	___	___
Unexplained Weight Loss	___	___
Varicose Veins	___	___
Venereal Disease	___	___
Type_____		
Other: _____		

Are you now, or have you been under the care of any doctor (other than your primary care physician) for any reason over the last two years? ___Yes ___ No If yes, Who & reason? _____

_____

TREATMENT CONSENT

I hereby consent and give my permission to Rochester Podiatry, Massimo Pietrantoni DPM FACFAS, his assistants and/or designated replacement to administer and perform such procedures upon me as the doctor deems necessary.

Signature of Patient or Guardian: _____ Date: _____

Please Print name of Patient or Guardian: _____ Relationship to Patient: _____