ROCHESTER PODIATRY

Board Certified Physicians and Surgeons

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Date of Appointment _____ When did your foot /ankle issue start? _____

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Sex ☐ M ☐ F Birthdate _____

Home Phone ( ) Cell ( ) Work ( )

Emergency, Contact: _____ Relationship to patient? _____ Phone #: ( ) _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separate ☐ Partnered ☐ Minor

Occupation _____ Employer & address _____

Spouse/Partner Info: Name: _____

Occupation: _____ Birthdate: _____

How did you hear about our office? ___ Internet ___ Urgent Care ___ Primary Physician ___ Other _____

Primary Care Physician: _____ Date of Last Visit: _____

Address: _____ Phone #: ( ) _____

Primary Physician's Hospital Affiliation: ____ **RRH** ____ **URMC** ____ **Other** _____

Preferred Pharmacy: _____ Phone #: ( ) _____

Address: _____

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

Reason for today's visit:

Insurance Assignment and Release

I certify that I have insurance coverage with my insurance company (ies) and assign Rochester Podiatry and its healthcare providers 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 Date

Medications: ____ NONE

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Surgeries: ____ NONE

_____ _____

_____ _____

_____ _____

Allergies: ____ NONE

__ Adhesive/ tape
__ Anticoagulant Therapy
__ Aspirin
__ Codeine
__ Demerol
__ Iodine
__ OTHER _____

_____

_____

__ Latex
__ Local Anesthetics
__ Penicillin
__ Metal/Nickel
__ Seafood
__ Sulfa

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
OTHER	___ 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
Rheumatoid Arthritis	___ Yes	___ No
Psoriasis	___ Yes	___ No

Other _____

PODIATRIC HISTORY

	Currently	Previously
Ankle Pain	___	___
Athlete's Foot	___	___
Bunions	___	___
Corns, Calluses	___	___
Numbness feet/legs	___	___
Flat feet	___	___
Use over the counter inserts	___	___
Use Custom 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	___	___
Type _____		
Chemical Dependency	___	___
Chest Pain	___	___
Cholesterol	___	___
Circulatory Issues (PVD)	___	___
Diabetes	___	___
_____ Type I ____Type II _____ Other		
_____ 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, its healthcare providers, assistants and/or designated replacement to administer and perform such procedures and treatments upon me as the they deem necessary.

Signature of Patient or Guardian: _____ Date: _____

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