

Welcome To Westside Podiatry Center

Patient Information:

Name _____ Date _____

Address _____ City/State _____ Zip _____

Home # _____ Work # _____ Cell# _____

Social Security # _____ Date of Birth _____ Age _____

Gender: M F Marital Status: S M D W Spouse _____

Employer _____ Address _____

Occupation _____

Family Doctor's Name _____ Phone# _____

Address _____

Insurance Information:

Primary Insurance _____ ID # _____ Group # _____

Secondary Insurance _____ ID # _____ Group # _____

Subscriber Information:

Name _____ Date of Birth _____

Social Security # _____ Relationship to Patient _____

Employer _____ Phone # _____

Emergency Contact: (Someone who is not living with you)

Name: _____ Phone # _____

Whom May We Thank For Referring You? _____

Please be advised that our office has a 24 hr. cancellation policy. Failure to notify our office if you are unable to keep your appointment will result in a fee of \$50 for new patients, and \$30 for established patients.

I authorize Dr. Farrell, Dr. Rounds, Dr. Wadie, and/or Dr. Smith to provide any insurance company, claim administrator, and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits. I hereby authorize payment directly to Dr. Farrell, Dr. Rounds, Dr. Wadie, and/or Dr. Smith of the benefits otherwise payable to me. Also I hereby give permission to Dr. Farrell, Dr. Rounds, Dr. Wadie, and/or Dr. Smith and their assistants to diagnose, administer medications, and perform such procedures as may be deemed necessary in the diagnosis/treatment of my feet and related conditions. I understand and agree that because of human variance and response it is not possible to warrant the outcome of any medical care or service.

Responsible Party Signature _____

Relationship _____ Date _____

Name _____ Birthdate ____/____/____ Appointment Date _____

Height _____ Weight _____
(to be filled out by nurse): BP _____ Pulse _____ Respiration _____
Shoe size _____

Reason for visit: (Be Specific)

Date of onset _____

Medical Doctor _____ Date last seen _____

Doctor treating for Diabetes _____ Date last seen _____

Former Podiatrist _____

Medical History (Circle only those items that apply)

Diabetes- diet/oral/insulin __ years?	Skin problems, psoriasis
Kidney disease	Gout
Anemia	Fibromyalgia
Peripheral vascular dis.	Fainting/Seizures
Arthritis , Rheumatoid, osteoarthritis, Lupus Neuropathy	
Liver disease, hepatitis, jaundice	Anxiety
High blood pressure	Depression
GI Ulcers, Stomach problems	Broken bones in feet or legs
Blood disease, bleeding disorder	Artificial heart valves or joints
Cancer	Chemical dependency
Heart disease, angina , chest pain	Weight loss or gain
Varicose veins	Back problems , herniation of discs / stenosis
Epilepsy,	Circulation problems
Hypothyroidism , Thyroid problems	Chronic diarrhea
Autoimmune disease, HIV, AIDS	MS
Rheumatic fever	CVA (stroke)
Asthma, emphysema, lung problems	High cholesterol
Eye pathology	Leg cramps/numbness
Charcot joint	Neuropathy
Gastric reflux, hiatal hernia	
Other Medical problems (please list): _____	

Surgical History (circle only those items that apply)

Foot Surgery: Type _____ Date: ____/____/____ RT/LT (Please Circle)

Angioplasty	D and C	Hip/knee replacement
Knee replacement	Arterial by-pass	Appendectomy
C-section	Venous ligation	Mastectomy
Cataract	Open heart	Kidney stone
Carotid artery	Back surgery	Kidney removal
Gall bladder	Back surgery	Pacemaker
Tonsillectomy	Prostate	Heart by-pass
Hysterectomy	Breast biopsy/lumpectomy	NONE

Patient Name: _____ Date: _____

Other Surgical History (please list):

Medications (please list, including non-prescription medications)

No current medications _____

Family History (please circle if positive)

	Arthritis	Diabetes	Heart disease	Cancer	High blood Pressure
Mother	yes	yes	yes	yes	yes
Father	yes	yes	yes	yes	yes
Siblings	yes	yes	yes	yes	yes

Social History (please check)

Alcohol _____

Tobacco _____ #packs per day? Caffeine (coffee, tea, soda) _____ #cups per day?

Recreational Drugs _____

Activities _____

Allergies (please circle)

No known drug allergies

Novocain

Iodine

Aspirin

Neosporin

Codeine

Motrin/advil

Penicillin

Cortisone

Adhesive tape

Sulfa

Latex

Other _____

Review of systems (filled out by nurse)

Cardiovascular hypertension / murmurs / chest pain / edema / claudication / ulceration / phlebitis

ENT difficulty swallowing / hoarseness / hearing loss / infection / ringing in the ear /
nose bleed / ear aches / sores

Gastrointestinal jaundice / cirrhosis / hepatitis / abnormal stool

HE dizziness / fainting / headaches / double vision / infection

Mental status alert and oriented / alert but not oriented / confused / lethargic

Musculoskeletal joint pain / joint swelling / muscle pain / poststatic dyskinesia / weakness / back
pain

Neurologic paralysis / stroke / tics / tremors / seizures

Respiratory asthma / bronchitis / difficulty breathing / shortness of breath / vomiting blood
/ emphysema

Tech: _____

WESTSIDE PODIATRY, LLP
JAMES W. FARRELL, DPM CHAD R. ROUNDS, DPM
EDWARD L. WADIE, DPM DANIEL T. SMITH, DPM

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (please print)

Parent or Authorized Representative (if applicable)

AUTHORIZATION TO RELEASE INFORMATION

I authorize the following individuals to have access to my "Protected Health Information."

Please list names:

Signature: _____ **Date:** _____

This form expires one year from the date of signature.