

ATLANTIC FOOT & ANKLE CENTER

Drs. Simon, Bava, Rayno and Pfeiffer are pleased to welcome you to their office. Please take the time to answer the following questions to help us get acquainted. If you need help, please do not hesitate to ask for assistance. Please have insurance card(s) and a picture I.D. along with any referrals available.

Patient _____	Phone () _____			
Address _____	City _____	State _____	Zip _____	
Single _____	Married _____	Widowed _____	Divorced _____	Date of Birth _____
Patient's SSN# _____ - _____ - _____	Age _____	Sex _____	Height _____	Weight _____
Emergency Contact Name and Number (not living with you) _____				
Patient's Employer _____	Work Phone # () _____			

Primary Insurance _____	ID # _____
Secondary Insurance _____	ID # _____
Spouse's Name _____	Date of Birth _____
SSN # _____ - _____ - _____	Employer Name and Phone # _____

What is your present foot problem? _____	
How long has it been a problem? _____	
Have you been treated for this in the past? _____	
Who is your Primary Physician? _____	Phone # () _____
Are you currently under his/her care for any medical problems, if so what? _____	

How did you hear about our office? _____

I hereby authorize treatment to the patient by the above physician and/or affiliated medical staff members. I further authorize release of any medical and/or charge information as is necessary for third party reimbursements from my insurance carrier. I authorize direct payment from said insurers to this practice. I accept responsibility for payment of all charges. I agree that should my account become delinquent and is referred to an attorney or collection agency for collection, I will be responsible for all costs of collection and attorney's fees of 35% of any unpaid balance at the time of referral.

Signature _____ Date _____

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PLEASE CHECK THE APPROPRIATE DIAGNOSIS THAT APPLIES TO YOU:

- | | |
|--|---|
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> _____ FOR HOW LONG | <input type="checkbox"/> SHOE SIZE |
| <input type="checkbox"/> INSULIN DEPENDENT | <input type="checkbox"/> NON-INSULIN DEPENDENT |
| <input type="checkbox"/> CHOLESTEROL | <input type="checkbox"/> COUMADIN THERAPY |
| <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> GOUT |
| <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> HEART PROBLEMS |
| <input type="checkbox"/> NERVOUS TROUBLES | <input type="checkbox"/> PREVIOUS BLOOD TRANSFUSION |
| (DEPRESSION/ANXIETY DISORDERS) | <input type="checkbox"/> PARALYSIS |
| <input type="checkbox"/> STROKE | <input type="checkbox"/> HIGH BLOOD PRESSURE |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DIFFICULTY SPEECH |
| <input type="checkbox"/> DIFFICULTY HEARING | <input type="checkbox"/> CANCER |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> _____ TYPE |
| <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> HEPATITIS |
| <input type="checkbox"/> STOMACH PROBLEMS | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> GALL BLADDER PROBLEMS | <input type="checkbox"/> KIDNEY PROBLEMS |
| <input type="checkbox"/> FAINTING SPELLS | <input type="checkbox"/> SKIN DISEASE |
| <input type="checkbox"/> THYROID | <input type="checkbox"/> CIGARETTE SMOKING |
| <input type="checkbox"/> SCARLET FEVER | <input type="checkbox"/> _____ HOW LONG? |
| <input type="checkbox"/> ARE YOU PREGNANT? | <input type="checkbox"/> _____ HOW MANY PER DAY? |
| <input type="checkbox"/> _____ DUE DATE? | <input type="checkbox"/> ALCOHOL USE |
| <input type="checkbox"/> ALLERGIES TO MEDICATIONS? | PLEASE LIST THEM: |

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? (INCLUDE HERBAL SUPPLEMENTS)

ANY SURGERIES IN YOUR LIFETIME, PLEASE LIST ALL WITH YEAR/DATES OR AGE.



ATLANTIC FOOT & ANKLE CENTER

William H. Simon, D.P.M.*
Joseph V. Bava, D.P.M.*
Michael J. Rayno, D.P.M.
Dawn M. Pfeiffer, D.P.M.
*Board Certified

Reconstructive Foot Surgery
Sports Injuries of the Foot and Ankle
General Foot Care
Diabetic and Arthritic Foot Care
Joint Replacement
Surgery of the Foot
Nail/Skin Disorders
Foot and Ankle Trauma

Podiatric Medicine & Surgery

PATIENT NAME: _____

DATE: _____

- REVIEW OF SYSTEMS:** Please circle any problems you have had or may now be having from the list below.
- CONSTITUTIONAL Fever, weight loss, weakness, fatigue
 - SKIN Dry skin, excessive sweating, coldness of hands or feet, rashes
 - HEMATOLOGICAL Swollen glands, easy bruising, hx. of blood transfusion, HIV exposure
 - HEENT Headaches, facial pain, sinus problems, allergies, visual or hearing problems, gum disease, problems with teeth, snoring, sleep apnea
 - CHEST Chest wall pain, cough, shortness of breath, breast lumps, nipple D/C
 - CARDIOVASCULAR Heart trouble, angina, swelling of feet, hypertension, heart murmur, irregular heartbeat
 - ABDOMINAL Liver disease, hepatitis, gall bladder problems, irritable bowel syndrome, colitis, diverticulitis, polyps, reflux, peptic ulcer, reflux, constipation diarrhea, dark stools
 - GENITOURINARY Kidney stones, kidney disease, bladder dysfunction, blood in urine, ovarian cysts, testicular masses, hernias, uterine fibroids, dysfunctional uterine bleeding, menstrual irregularities, sexual impairment, reduced libido (desire for sex)
 - ENDOCRINE Thyroid problems, hormonal changes, diabetes, excessive thirst, recent weight gains or loss
 - MUSCULOSKELETAL History of neck or low back pain, arthritis, joint pain, muscle pain, bone pain, stiffness, gou hip/shoulder or knee problems, carpal tunnel, foot or ankle pain, heels spurs
 - NEUROLOGICAL Seizures, fainting spells, stroke, weakness, neuropathy, dizziness, tremors, gait problems, memory, or concentration difficulties, depression, anxiety, shakiness, anger, guilt, agitation

Reviewed by: _____ Date: _____

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*Certified by the American Board of Podiatric Surgery
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