BAY HARBOR PODIATRY GROUP

WELCOME TO OUR OFFICE!

Email Address _____
Patient's Name _____Cell Phone # (____) _____
Home Phone # (____)_____Work Phone # (____) _____
Home Address_____ City_____ Zip_____
Birthdate ___ / ___ / ___ Age ___ M ___ F ___ Single ___ Mar.___ Div.___ Wid.___ Sep.___
Preferred Language: ☐ English ☐ Spanish ☐ Japanese ☐ Chinese
Ethnicity_____ Race_____
Patient's Soc. Security #_____-____-_____ Drivers License #_____
Patient's Occupation_____ Employer's Name_____
Employer Address_____ Phone # (____) _____
Who is Resp. for Health Insur. / Bills / Relation to Patient _____
Name of Spouse / Parent_____ Birthdate of Spouse / Parent___/___/___
Spouse / Parent's Occupation_____ Spouse / Parent's Employer_____
Employer Address_____ Phone # (____)_____
Spouse's Social Security #_____-____-_____ Spouse's D.L.# _____
Closest Relative or Emergency Contact NOT living with you_____
Address of Closest Relative_____Ph. No._____
Name and Address of Insurance Co._____
ID #_____ Grp #_____ Ins. Co. Phone # (____) _____
Secondary Insurance Co._____ Address_____
Secondary Ins. Co. Phone # (____) _____ ID #_____ Grp #_____
Family Physician Phone # (____) _____
Family Physician Name and address_____
Preferred Pharmacy:_____ Location: _____
Describe your Foot Problem _____
_____Height_____ Weight_____ Shoe Size_____

How were you referred to our office? _____

I hereby give permission to Bay Harbor Podiatry Group, Marc G. Mittleman, D.P.M., and Associates, or whomever may be designated to: Photograph, administer treatment, and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY FINANCIAL OBLIGATION INCURRED DURING THE DIAGNOSIS AND/OR TREATMENT OF MY CONDITION.

Signature:_____ Date:_____

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 understand the Notice.

Patient Name_____ Date:_____

Parent or Authorized Representative (if applicable)_____

Signature_____

HEALTH QUESTIONAIRE

Name_____ Date_____

Have you ever been informed by a doctor that you have:
(please circle)

Arthritis ……yes no

Gout……...yes no

High Blood Pressure……yes no

Thyroid Trouble……yes no

Heart Trouble……yes no

Cancer……yes no

Poor Circulation……yes no

Neurological Problems…… yes no

Diabetes……yes no

Stomach or Intestinal Ulcers……..yes no

Hepatitis……yes no

Kidney or Liver Disease……..yes no

Rheumatic Fever/Scarlet Fever……yes no

Skin Conditions (such as Psoriasis or Rash).. yes no

Breathing Problems (asthma, emphysema, tuberculosis (TB))….. yes no

Have You Ever Had a Blood Transfusion? Or Blood Borne Disease? yes no

Are you taking any medications now? (please list all)_____
_____

Are you ALLERGIC to any medications or foods? (such as pain medications, antibiotics, sulfa, iodine, anesthetics, adhesive tape, others)
_____

Prior Operations or
Hospitalizations?_____

Traumatic Injuries or Broken Bones?_____

Any Complications from Childhood Diseases?_____

Any Serious or Life Threatening Infections?_____

When was your last physical exam?_____Did you have an EKG?_____

Did you have a chest X-ray?_____Were the findings normal?_____

Do you smoke?_____If so, how much?_____

Do you drink alcohol?_____ If so, how much?_____

IS THERE ANY POSSIBILITY THAT YOU COULD BE PREGNANT? YES NO

Additional medical information: _____