FHC
FOOT HEALTH CENTER

FOOT HEALTH CENTER, L.L.C./PATIENT HEALTH HISTORY FORM

Name: _____ **Date:** _____

Gender: (Male) (Female)

Name of Primary Care Physician (Address and Phone # if known) _____

Pharmacy Name (Address and Phone #) _____

Age: _____ **Height:** _____ **Weight:** _____

Please list ALL medications you are taking (prescriptions and/or over the counter): _____
_____

Do you have any Allergies?(Food/Drugs/Latex/Seasonal) _____
If yes, what is your reaction? _____

Chief Complaint/Concern:_____
_____

Describe your pain (circle those that apply);
sharp/burning/shooting/achy/knifelike/twisting/pressure/toothache/deep/heavy/gnawing/throbbing/dull/pulsating

How long have you experienced pain for? _____

What makes pain worse? _____**What makes pain better?** _____

What medicines have you taken for your pain? _____

How severe is your pain? _____
0(no pain) 1-2(tolerate without medication 3-4(tell someone about my pain, take aspirin or Motrin)
5-6(mild narcotic, ex. Tylenol #3), 7-8(go to the emergency room, take strong narcotic) 9-10(admission to the hospital for pain control)

Immunizations: Are they up to date? Yes/ No Date of Last Tetanus Shot _____

PAST MEDICAL HISTORY (please circle any that apply)
Hypertension/ High Cholesterol/ Asthma/Diabetes/ Arthritis/ Back Injury/ Cancer/ Peptic Ulcer/ Gastric Reflux/ Heart Disease/Angina/ Arrhythmia/ Mitral Valve Prolapse/ Seizures/HIV/ Hepatitis/ Gout/ Sickle Cell Disease/ Kidney Disease/ Other_____

Past Surgeries_____

Social History: Type of job _____

Do you smoke? Yes/ no **Have you ever smoked?** Yes/ No If yes, how many packs/ day? **For how many years?** _____

Do you consume alcohol? If yes, how much/often? _____

Who do you live with? _____

Hobbies/Sports: _____

Family History: List any diseases of parents, siblings, children , or grandparents:
_____

For Women Only: Are you pregnant or nursing? _____

Review of Systems: Please circle any that apply:

CONSTITUTIONAL: weight change, weakness, fatigue, fever

EYES: glasses, pain, tearing, double vision

EARS, NOSE, MOUTH AND THROAT: tinnitus, dizziness, pain, sinus, colds, sore throat

CARDIOVASCULAR: high blood pressure, rheumatic fever, murmurs, shortness of breath, chest pain, palpitations

RESPIRATORY: cough, sputum, coughing up blood, wheezing asthma, bronchitis, chest pain, breathing problems

GASTROINTESTINAL: difficulty swallowing, heartburn, vomiting, diarrhea, indigestion, pain, blood, stool changes

GENITOURINARY: pain with urination, urinating at night, blood in urine, urgency, hesitancy, incontinence

SKIN: rash, lumps, Itching, dryness, color change, hair changes, nail changes

NEUROLOGICAL: fainting, blackouts, seizures, paralysis, memory loss

PSYCHOLOGICAL: nervousness, tension, mood changes, depression, anxiety

ENDOCRINE: heat or cold Intolerance, sweating, thirst, hunger, change in urination

HEMATOLOGY/LYMPHATICS: bruising, bleeding, transfusion reactions

ALLERGIES/ IMMUNOLOGICAL: drug, product or other allergies

REPRODUCTIVE: sexual dysfunction, pregnancy

MUSCLE/SKELETAL: back, joint, or muscle pain

Comments:

_____

_____Date

Dr. Michael V. Verdi, D.P.M.
Dr. Jordan S. Steinberg,D.P.M.

FOOT HEALTH CENTER, LLC/ PATIENT DEMOGRAPHICS FORM

Patient Name:

(Last)_____(First)_____(M)_____

Street Address_____Apt # if applicable_____

City:_____ State_____ Zip_____

Home Telephone_____CellNumber_____Worknumber_____

Email:_____ SS#_____ DATE OF BIRTH_____

Name of Parent(s)(if child is patient)_____Name of Spouse(if married)_____

Emergency Contact (Name & Telephone)_____

Referral source_____

Primary Language_____Race_____Ethnicity_____

Contact Preferences ( ) Phone ( ) Mail ( ) Email

Our current privacy practices do allow us to call you with a courtesy reminder call regarding upcoming appointment(s).

Please leave my courtesy reminder calls for upcoming appointment on the following number_____

Ok To leave message with ( )Patient Only ( ) Patient and/or Family member ( ) Anyone Answering

If you do not wish to have courtesy reminder calls for upcoming appointments, please be aware that there is a cancellation fee of $25.00 if not cancelled within 24 hours, please initial_____

From time to time In caring for our patients, it may become necessary to contact you by telephone. Often our patients are not available when we call them and we would like to leave detailed messages (i.e. lab results, orthotics, surgery times, etc.) when possible. In order to protect your privacy we need your written permission to leave such detailed telephone messages on you answering machine or voice mail system.

I, _____(signature), give Foot Health Center, LLC and their staff my permission to leave telephone messages regarding my medical care at the following number(s):

( ) Home phone/answering machine ( ) Cell number/voicemail ( ) Spouse/ anyone answering phone ( ) Other

Please present primary and secondary insurance card(s) so we may make a copy. If you do not have your card you will be responsible for services rendered at that time, due to the overwhelming addresses for each insurance company and the necessity of having your ID#. As well as if a referral is needed you need to supply at time of visit. Please take not this office will only submit to two insurances. If this is workers compensation, auto claim, or claims going to your lawyer, please supply that information on date of service... But please take note you will ultimately be responsible for bill.

Do you have medical insurance: (yes) (no)

*If Billing address is different than patient address*_____

What is your relationship to Policy Holder? (Self) (Spouse) (Child)

Insurance Information:

Primary Insurance:

Company Name:_____ Insurance#_____Group#_____

Address_____

Copay (amount)_____Deductible(amount and if met)_____Coinsurance_____

Referral (if needed, please supply number)_____

Policy Holder Information (if not self)

Name_____Address(if different)_____

Policy holder date of birth_____Policy holderSS#_____

Secondary Insurance:

Company Name:_____Insurance#_____Group #_____

Address_____

Copay(amount)_____Deductible(amount and if met)_____Coinsurance_____

Referral (if needed, please supply number)_____

Policy Holder Information (if not self)

Name_____Address (if different)_____

Policy holder date of birth_____Policy holder SS#_____

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM(s) AND HEREBY ASSIGN FOOT HEALTH CENTER,LLC (DR. MICHAEL VERDI & DR. JORDAN STEINBERG) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO SELF OR DEPENDENTS.

I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ALL OF THE CHARGES FOR ALL OF THE SERVICES AND/ OR PRODUCTS RENDERED TO ME OR ANY MEMBER OF MY FAMILY.

ALTHOUGH I HAVE REQUESTED THE DOCTOR TO BILL MY INSURANCE COMPANY ON MY BEHALF, I CLEARLY UNDERSTAND THAT IF A BILL IS NOT PAID BY MY INSURANCE WITHIN A TIMELY MANNER, I AGREE TO MAKE ARRANGEMENTS FOR PROMPT PAYMENT TO FOOT HEALTH CENTER, LLC.

I AGREE TO HAVE A VALID REFERRAL (IT IS POLCYHOLDER'S RESPONSIBILITY TO KNOW IF INSURANCE REQUIRES REFERRAL) FOR VISIT AND ANYTIME INSURANCE CHANGES.

PLEASE NOTE: IF YOU HAVE NO INSURANCE YOU WILL BE RESPONSIBLE FOR PAYEMENT AT TIME OF SERVICES.

Patients Signature:_____

Guardian or other responsible party Signature:_____

Today's Date:_____