Elmhurst Podiatry Center, LTD.

Disease and Surgery of the Foot and Ankle

Dr. Jared P. Frankel, D.P.M. **Dr. Robert Turf D.P.M.**

WELCOME TO OUR OFFICE

NAME_____
LAST FIRST MIDDLE

ADDRESS_____
STREET APT# CITY STATE ZIP

HOME PHONE(____)_____ WORK PHONE (____)_____ E-MAIL _____

AGE_____ BIRTH DATE _____ SOCIAL SECURITY # _____-_____-_____ SEX (CIRCLE) M F

YOUR OCCUPATION_____ EMPLOYER _____

EMPLOYER'S ADDRESS _____

EMERGENCY CONTACT _____ (____) _____
NAME PHONE

MARITAL STATUS (CIRCLE) S M W D NAME OF SPOUSE_____

DO YOU HAVE INSURANCE? ❑ YES ❑ NO *if yes we'll need to copy your card(s)* **THIS SECTION MUST BE COMPLETED.**

IS IT YOUR POLICY ❑ YES ❑ NO WHOSE POLICY IS IT? _____

Date of Birth:_____

ARE YOU COVERED UNDER ANY ADDITIONAL HEALTH INSURANCE PLANS? ❑ YES ❑ NO

NAME OF (HUSBAND) (WIFE) OR (PARENT) _____ DATE OF BIRTH_____

EMPLOYED BY _____ OCCUPATION_____

ADDRESS _____ PHONE NUMBER _____

SOCIAL SECURITY NUMBER _____

* If you did not bring insurance cards with you, all charges will be your responsibility and payable at the time of service. Obtaining required referral forms and treatment pre-certification is the patient's responsibility.

ALL UNPAID BALANCES AND/OR DENIED CLAIMS ARE YOUR RESPONSIBILITY.

NAME OF PRIMARY INSURANCE _____

NAME OF SECONDARY INSURANCE_____

NAME OF ADDITIONAL INSURANCE PLANS _____

PHYSICIAN'S NAME _____ PHONE (____) _____ FAX (____) _____

PHYSICIAN'S HOSPITAL AFFILIATION _____ DATE OF LAST VISIT _____

HOW WERE YOU REFERRED TO OUR CARE ? _____

• WHAT IS YOUR FOOT PROBLEM? _____

• FOR HOW LONG HAVE YOU HAD THE PROBLEM? _____ HAVE YOU BEEN TREATED FOR IT? ❑ YES ❑ NO

BY WHOM? _____

IS YOUR FOOT PROBLEM THE RESULT OF WORK-WORK RELATED INJURY? ❑ YES ❑ NO

MEDICAL INFORMATION

Past Medical History

Have you ever had any of the following?

- ❑ Measles
- ❑ Mumps
- ❑ Chickenpox
- ❑ Whooping Cough
- ❑ Scarlet Fever
- ❑ Diphtheria
- ❑ Smallpox
- ❑ Pneumonia
- ❑ Rheumatic Fever
- ❑ AIDS or HIV+
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Balance Problems
- ❑ Bladder Problems
- ❑ Blood Clots
- ❑ Bowel Problems
- ❑ Cancer
- ❑ Diabetes
- ❑ Digestion Problems
- ❑ Dizziness
- ❑ Ear/Nose Throat Problems
- ❑ Epilepsy
- ❑ Fainting
- ❑ Fevers over 103°
- ❑ Heart Disease
- ❑ High/Low Blood Pressure
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Migraine Headaches
- ❑ Numbness/Tingling
- ❑ Pacemaker
- ❑ Polio
- ❑ Prolonged Bleeding
- ❑ Psychological Problems
- ❑ Sexually Transmitted Disease
- ❑ Skin Problems
- ❑ Stroke
- ❑ Swelling of Feet/Ankles
- ❑ Tuberculosis
- ❑ Thyroid Disease
- ❑ Ulcer
- ❑ Varicose Veins
- ❑ Vision Problems
- ❑ Other _____

_____

HEIGHT _____ **WEIGHT** _____

Previous Hospitalization/Surgeries/Serious Illness (and When?) _____

_____

_____

_____

What medications &/or vitamins are you taking now and what dose? _____

_____

_____

_____

(Women) Are you pregnant? ❑ Yes ❑ No **Are you taking Birth Control Pills?** ❑ Yes ❑ No

Are you under care of a pyhsician? ❑ Yes ❑ No **If yes, for what reason(s)?** _____

Social History

Do you live alone? ❑ Yes ❑ No **For how long?** _____

Do you have Children? ❑ Yes ❑ No **If yes, how many?** _____

Do you exercise? ❑ Yes ❑ No **If yes, how often?** _____ **What kind of exercise?** _____

Are you on a special Diet? ❑ Yes ❑ No **If yes, what kind?** _____

Do you smoke? ❑ Yes ❑ No **If yes, how many packs per day? #** _____ **for #** _____ **years.**

If no, when did you quit? _____ **How many packs had you smoked? #** _____ **per day for #** _____ **years.**

Do you drink alcohol? ❑ Yes ❑ No **How much** _____**Daily** _____**Weekly** _____ **Monthly** _____ **Yearly**

Do you have a history of substance abuse? ❑ Yes ❑ No **If yes, What substance(s)?** _____

MEDICAL INFORMATION

Family History

Has anyone in your family ever been diagnosed with the following? Name the relationship next to the condition in the space provided.

❑ **Heart Disease** _____ ❑ **Cancer** _____ ❑ **Diabetes** _____

❑ **Circulatory Disease** _____ ❑ **Hypertension** _____ ❑ **Arthritis** _____

❑ **Neurological Problems** _____ ❑ **Skin Disease** _____ ❑ **Foot Problems** _____

Additional space, if necessary _____

_____

Allergies

Do you have a history of skin reaction or other adverse reaction to:

❑ **Anesthetics** _____ ❑ **Codeine** _____ ❑ **Penicillin** _____ ❑ **Tetanus** _____

❑ **Antibiotics** _____ ❑ **Foods** _____ ❑ **Seasonal Allergies** _____ ❑ **Other** _____

❑ **Aspirin** _____ ❑ **Iodine** _____ ❑ **Silver** _____

❑ **Environmental Substances** ❑ **IV Dye** _____ ❑ **Sulfa** _____

_____ ❑ **Pain Medication** _____ ❑ **Tape** _____

Specify above and any others: _____

_____

NOTES: _____

_____

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_____

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_____

To the best of my knowledge, the above information submitted is correct. I understand that giving incorrect information can be dangerous to my health. It is my responsibility to inform the doctors' office of any changes in my medical status. I, hereby, give my permission to DRS. Turf & Frankel to diagnose and administer treatment of my foot condition.

Signature _____ Date _____ *Reviewed by:* _____