Foot & Ankle Associates, P.C.
Dr. Dominick Garibaldi, D.P.M.

Today's date: ____________

Patient Name: ____

Address: ____

City, State, Zip: ____

Home Phone: ______________________ Work/Cell Phone: __________________

Sex: M/F Date Of Birth: _____________ Age:_____ Marital Status: S M W Sep D

Weight: ______________ Height: ___________ Shoe Size:_____________

Race:______________ Ethnicity: _______________ Language:_________________

Social Security#: ________________ E-mail ___________________

Employer: ___________________________ Occupation:___________________

What brings you to the office today? ____________________________________
____

Subscriber Information if other than patient

Name: ______________________________________ DOB: ____________________

SS#: _______________________________ Relationship to patient: ________________

Billing Address: ____

City, State, Zip: ____

Home Phone: __________________________ Work/cell Phone: __________________

Emergency Contact/Next of Kin

Name: ____

Address: ____

Phone: ______________________________ Relationship to Patient: _______________

OFFICE POLICY REGARDING INSURANCE

To preserve the best possible relationship with you, our patient, and to prevent any misunderstandings, we hope the following explanation of our office policy regarding insurance and payment for services is helpful.

1) We expect and appreciate payment for office visits at the time of service. We will accept cash, check, MasterCard or Visa.

2) For any insurance plan that requires authorization from a primary care physician (e.g. HMO, PPO, etc) it is your responsibility (as patient or guardian) to be sure that this office receives all necessary referral or authorizations PRIOR to treatment. If the insurance carrier denies any charges due to lack of referral/authorization, you (the patient/guardian) are responsible for all charges incurred.

3) If any type of supplies are dispensed during the course of treatment, (e.g.arch support, accommodative pads, cream, surgical shoes, etc.) payment is due at the time of service. We cannot bill you or the insurance company for these supplies.

4) I have read, understand and agree to the above office policies and understand that I am financially responsible for any balance due on my account.

5) 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.

6) I hereby give my permission to Foot & Ankle Associates to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition

Signature (Patient/guardian):_____________________________ Date: _______________________

Medical History

Primary Care Physician:______________________________ Last Visit: ________________

Address:____ Phone #:__________________

Pharmacy:______________________________________ Phone#:___________________

Are you allergic to any medications? Y/N
If Yes please list: ____

Are you currently taking medications? Y/N
If yes please list: ____

WOMEN ONLY: Are you Pregnant? Y/N Planning a pregnancy? Y/N

Do you have or have you ever been treated for: (please circle)

Major Disease
Diabetes
High Blood Pressure
Angina
Heart Disease
Heart Attack
Mitral Valve Prolapse
Stroke
High Cholesterol

Arthritis
Osteoarthritis
Rheumatoid
Gout

Gastrointestinal
Ulcers
Acid Reflux
Stomach Problems
Hiatal Hernia
GI or Rectal Bleeding
Bowel Disorder

Psychological
Anxiety
Depression
Psychiatric Care
Drug Dependence
Alcohol Dependence

Vascular
Anemia
Prolonged Bleeding
Pacemaker
Poor Circulation
Leg Pain when walking
Varicose Veins
Blood Clots

HEENT
Headaches
Glaucoma
Hearing Problems

Respiratory
Asthma
Tuberculosis
Emphysema

Miscellaneous
Epilepsy / Seizures
Thyroid Disease
Muscle Disease / Polio
Kidney Problems
Bladder Problems
Prostate Problems
HIV
Hepatitis / Liver Disease
Cancer (type: ________)

Past Surgical Procedures:

Surgery	Date	Reason

Social History:
Smoke: Y/N Pack(s) a day? _____ How Long?______
Caffeine: Quantity__________ Alcohol: ________
Recreational Drug Use? ___________________________
Type of exercise/sports: ___________________________
Family History:
Does any one in your family have or ever been treated for (Please specify family member Mother, Father, Siblings, Children, Grandparents.):

Heart Disease
Cancer
Epilepsy/convulsions
Thyroid Disease

High blood pressure
Glaucoma
Bleeding disorder
Mental Illness

Stroke
Diabetes
Kidney Disease
Osteoporosis

Mother: Alive Deceased (cause of death) ______________________________
Father: Alive Deceased (cause of death) ______________________________