NEW PATIENT PACKET

Patient Name: _____
DOB: _____

Address: _____ ___ SS#: _____

City, State, Zip Code:

_____

Mailing Address if different:

_____

Phone (primary): _____ Phone (secondary): _____

Email: _____

Emergency Contact Name & Relation: _____

Emergency Contact Number: _____

Employer/Occupation: _____
Height: _____ Weight: _____ Shoe size: _____ Age: _____

Gender: Male Female

Race/Ethnicity: _____ Language of Choice: _____

Are you pregnant? Yes No If so, how far along? _____

Preferred Pharmacy: _____ City: _____

Primary Care Physician (PCP) Name: _____

PCP Number: _____ PCP City: _____

Who were you referred by? _____

If Patient is a Minor

Guardian/Guarantor Name: _____ DOB: _____

Address: _____

Phone: _____ Email: _____

Allergies: Please list any allergies to medicine or food below:

_____
_____
_____

_____
_____
_____

_____
_____
_____

Please list current medications or attach a list:

_____
_____
_____

_____
_____
_____

_____
_____
_____

_____
_____
_____

Previous Surgery:

Have you had any of the following surgeries before?

Foot or Ankle surgery:

_____

_____

Heart surgery, pacemaker, defibrillator:

_____

_____

Bypass or stents in legs:

_____

_____

Joint replacements:

_____

_____

Other major surgeries:

_____

_____

Family History: Please list health problem and who has them

_____

_____

_____

_____

_____

_____

_____

_____

Social History:

Do you smoke? Yes No If so, how much? _____

Are you a former smoker? Yes No

Do you drink alcohol? Yes No

Do you use any illegal drugs? Yes No

If over 65, Do you have a Medical Power of Attorney? Yes No

Name of Medical Power of Attorney _____ Relationship _____

PLEASE CIRCLE ANY OF THE FOLLOWING HEALTH PROBLEMS YOU MIGHT HAVE:

AIDS/HIV
ALZHEIMER'S DISEASE
ANEMIA
ANXIETY
ARTHRITIS
ARTIFICIAL JOINTS
ASTHMA
BACK PAIN
BIPOLAR
BLEEDING DISORDER
BLOOD CLOT
BRONCHITIS
CANCER
CONGESTIVE HEART FAILURE
CORONARY ARTERY DISEASE
DEEP VEIN THROMBOSIS
DEPRESSION
DIABETES
DIALYSIS
DYSLIPIDEMIA
EDEMA
EMPHYSEMA
FIBROMYALGIA
FOOT DEFORMITY
GASTROESOPHAGEAL REFLUXE DISEASE
GOUT
HEADACHES
HEART ATTACK
HEART DISEASE
HEPATITIS
HERNIA
HYPERCHOLESTEROLEMIA
HYPERTENSION
KIDNEY DISEASE
LEG OR FOOT ULCERS
LIVER DISEASE
LUND DISEASE
NEUROPATHY
OBESITY
ORGAN TRANSPLANT
OSTEOPOROSIS
PERIPHEAL VASCULAR DISEASE
PULMONARY EMBOLISM
RAYNAUD'S DISEASE
RHEUMATOID ARTHRITS
SEIZURES/EPILEPSY
SLEEP APNEA
STROKE
THYROID PROBLEMS
VARICOSE VEINS

PLEASE CIRCLE ANY OF THE FOLLOWING HEALTH PROBLEMS YOU MIGHT HAVE:

Constitutional

Fever Night Sweats Weight loss Exorcise Intolerance

Eyes

Dry eyes Irritation Sinus Problems

Ears

Difficulty Hearing Ear Pain

Nose

Nose Bleeds Nose Problems Sinus Problems

Mouth

Bleeding Gums Snoring Dry Mouth Mouth Ulcers Teeth Abnormalities

Cardiovascular

Chest Pain Shortness of Breath Palpitations Heart Murmur Light Headed

Respiratory

Cough wheezing Coughing up Blood Sleep Apnea

Gastrointestinal

Abdominal Pain Vomiting Chang in Appetite Black Stools Diarrhea

Vomiting Blood Dyspepsia GERD

Genitourinary

Loss of Urinary Control Difficulty Urinating Increased Urinary Frequency Hematuria

Incomplete Emptying

Musculoskeletal

Muscle Aches Weakness Joint Pain Back Pain Swelling in the Extremities

Integumentary

Moles Jaundice Rash Itching Dry Skin laceration

Neurologic

Loss of Consciousness Numbness Seizures Dizziness Headaches/Migraines
Restless Legs Tremor

Psychiatric

Depression Sleep DisturbancesRestless Sleep Alcohol Abuse Anxiety
Hallucinations Suicidal Thoughts

Endocrine

Fatigue Increased Thirst Hair Loss Hair GrowthCold Intolerance

Hematologic/Lymphatic

Swollen Glands Easy Bruising Excessive Bleeding

Allergic/Immunologic

Runny Nose Sinus Pressure Itching Hives Sneezing

Current Problem

What brings you in today? _____

_____

Are you having pain? Yes No

Sharp Stabbing Dull Aching Burning Tingling Throbbing Numbness
Other: _____

Where is pain located? _____

_____

How long have you had this pain? _____

_____

What makes this pain better? _____

_____

What makes this pain worse? _____

_____

Have you seen anyone else for this problem? Yes No If so, Who?

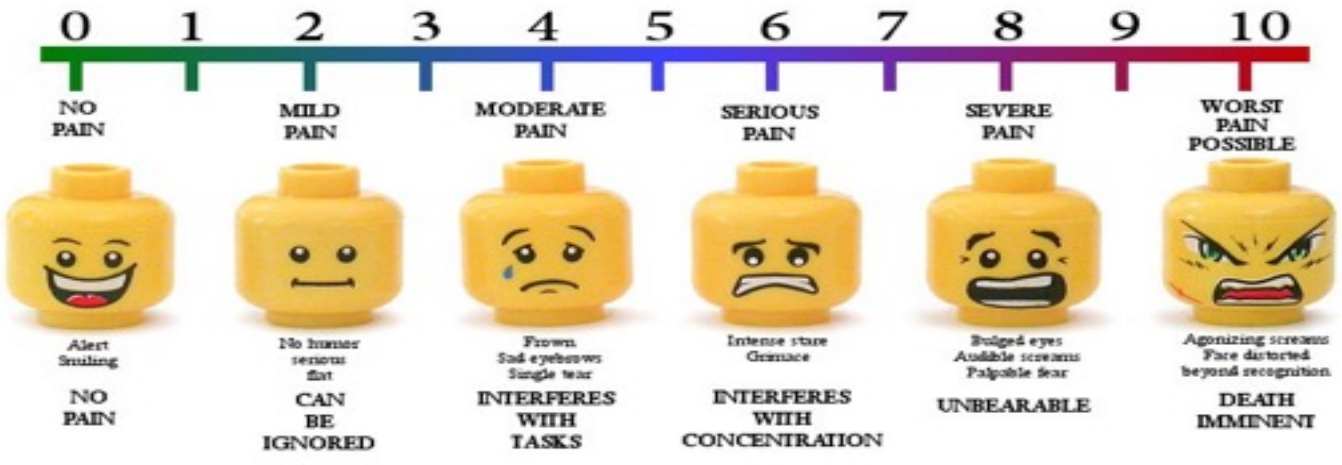
_____

What treatment/treatments have been previously attempted?

_____

_____

Rate your pain for today on the scale below: _____



Assignment of Benefits, Privacy Information/HIPPA Notice,

Patient Permissions

Authorization/Responsibility Agreement

I hereby authorize my insurance company to pay the proceeds if any are due, directly to Richard S. Kobylar DPM/Vorice Batts, DPM/ JC Tanenbaum, D.P.M., P.A. & Associates. A copy of this can be considered as an original for insurance purposes.

_____ _____

Patient Signature/Guardian/Guarantor **Date**

I acknowledge and understand that I am responsible for all charges for services rendered to me by this office. Although I have requested the doctor to bill my insurance company on my behalf, I clearly understand that it is my responsibility to make sure the bill is paid. If for any reason my insurance company does not cover the service that was rendered to me I understand I am responsible for payment immediately. If you are signing as a guarding or for a minor you are also signing in agreement for all of the above.

_____ _____

Patient Signature/Guardian/Guarantor **Date**

Notice of Privacy Practice/Patient Acknowledgement

I have had the opportunity to read the Notice of Privacy Practice posted in the waiting room or I have received a copy. The Notice provided in details the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the right to change the terms of the Notice of Privacy Practice.

_____ _____

Patient Signature/Guardian **Date**

I give the doctors in this office permission to electronically retrieve my medication history from my online pharmacy database to assist in my medical care. I am aware I can revoke this permission at any time.

_____ _____

Patient Signature/Guardian **Date**

I understand that I will have to call this office for any results if I haven't received them in 2 weeks. Results will ONLY be released to the patient or guardian. I also understand there is access to my records through the online portal. Our office can assist you in setting up your online portal to review your records.

_____ _____

Patient Signature/Guardian **Date**