West Coast Podiatry Center

1611 53rd Ave W., Bradenton, FL 34207 (*941-753-9599*)
1961 Floyd Street, Suite D, Sarasota, FL 34239 (*941-366-2627*)

Dr. Stephen D. Lasday   Dr. Robert M. Goecker   Dr. Alissa Zdancewicz   Dr. Eric Vonherbulis   Dr. Dustin Stroud

Patient Information

NAME: First: __________________________MI: _____ Last: _____________________________ DOB: ____________

[*Sex*: ____ M _____ F_____ Other] [*Race*: ____White ____African Am ____ Hispanic ____Asian ____American Indian]

[Marital Status: (circle) Single Married Divorced Widow

Local Address ____________________________________Apt# ______City ____________________Zip Code _________

****IS THIS A NURSING HOME OR ASSISTED LIVING FACILITY? ____YES ____NO**

Ph No: _________________Cell : _________________ Work Name: _____________________Ph#_______________

Em**ergency Contact __________________________Relationship to Patient: ________________Ph No: ______________**

PERMANENT RESIDENT OF FLORIDA? Yes No E-Mail ____

Northern Address _________________________________City _________________ST ______Zip Code__________

Ph No (   ) __________________________ **Snowbirds?** From ___________________to ___________________

***IF YOUR INSURANCE IS THROUGH ANOTHER PERSON, PLEASE FILL IN BELOW

Relationship to patient: Spouse _____Parent ___Legal Guardian ___Other ___________________________

NAME: First: ________________________MI: ______ Last: ______________________________ DOB: ___________________

Address ______________________________________City ________________________ST ________Zip Code _______________

Ph No (   ) ____________________ Work Ph No: (   ) __________________ Employer: ___________________________

Guarantor Social Security No: _________________________

I authorize the physicians at West Coast Podiatry to submit insurance claims on my behalf. I authorize and assign benefits, payable by my primary and secondary insurance companies for my medical claims, to West Coast Podiatry Center, Inc. ***I agree that I am responsible for my deductible, co-pay and non-covered charges the day of the service. I will also assume full responsibility for all incurred charges my insurance company allows but does not pay. (All accounts must be kept current within 30 days of receiving a bill unless other arrangements have been made.)***

I realize that I am here for medical advice and possible treatment. I give permission to my treating doctor at West Coast Podiatry to perform those procedures that we have mutually agreed upon and to release my personal and/or medical information to other professional providers so that I may receive medical services from them. I understand that no guarantees or assurances have been made as to the results of any procedures or treatments.

SIGNATURE____ Date __________________________________

MEDICAL HISTORY

Name: ________________________________ Height: _________ Weight: ________Shoe Size: _____

Describe the condition that brought you to our office, including the location and duration of the problem:

____

____

****IS THE ABOVE PROBLEM RELATED TO AN AUTO ACCIDENT OR WORK INJURY?** **YES** **NO**

Are you seeing OR have you seen any doctor in the last year for an **INJURY RELATED TO A CAR ACCIDENT, WORK RELATED INJURY OR ANY OTHER INJURY?** _____**YES** ______**NO**

Do you have *HOME HEALTH or HOSPICE* coming to your home? **Yes** **No**

Do you live in an *Assisted Living Facility or a Skilled Nursing Home*? **Yes** **No**

Family Doctor: ______________________________Ph No ____________________Date Last Seen ___________

Diabetic Doctor: ______________________________Ph No ____________________Date Last Seen ___________
Date Last Blood test: _________________________A1C: ____________________

Heart Doctor: ______________________________Ph No ____________________Date Last Seen ___________

Vascular Doctor ______________________________Ph No ____________________Date Last Seen ___________

Pharmacy Name: ____**Ph No** __________________________

1. LIST ANY SURGERIES:

____

____

2. LIST ALL MEDICATIONS: (or bring a list)

____

____

3. ALLERGIES: ____

SOCIAL HISTORY

SMOKING? ______-NEVER _____-FORMER (YR QUIT:______) ____OCCASIONAL ____DAILY(#PACKS____)

ALCOHOL? _____NO ____YES, PRIMARILY _____ BEER ______ WINE______ HARD LIQUOR (HOW MANY DRINKS? _______PER DAY_______ PER WEEK)

RECREATIONAL DRUGS? ____NO ___YES

EXERCISE? ______NONE ______OCCASIONALY_____DAILY (What type: ____________________________)

FAMILY HISTORY:

MOTHER: ALIVE? YES NO (IF NO, CAUSE OF DEATH: _________________________________)

FATHER: ALIVE? YES NO (IF NO, CAUSE OF DEATH: _________________________________)

DO ANY BLOOD RELATIVES SUFFER FROM? Which Relative ______________________________
____Diabetes ____Heart Disease ____Cancer ____Bleeding Tendencies ____Other ______

OFFICE USE ONLY:
VITALS BP______________________PULSE ______________________RESPIRATIONS__________________

Name___________________________________ Date: __________

***Please check all that apply*.**

____Weight Loss ____Weight Gain
____Fever
____Fatigue
____Headache(s)
____Dizziness
____Head Injury-Date: ______ Cause: ________________________________
____Cataracts
____Glaucoma
____Eyeglass Use

____Asthma
____COPD
____Bronchitis
____Shortness of breath
____Hypertension (high blood pressure)
____Varicose Veins
____Leg Swelling
____Leg pain when walking
____Cold Feet
____High Cholesterol
____Irregular heart beat
____Heart attack-Approximate Date______
____Stroke- Approximate Date______

____Hernia
____Hepatitis Type: _____A _____B _____C
____Heartburn
____GERD
____G.I Bleeds
____IBS (Irritable Bowel Syndrome)
____Cirrhosis

Name: ____________________________________

_____Arthritis (please specify type) ____
_____Back Problem (please specify) ____
_____Spinal Stenosis
_____Fibromyalgia
_____Muscle Weakness
_____Drop Foot
_____Gout-Last Episode_______ Last Uric Acid Screening_______
_____Osteoporosis
____

_____Depression
_____Anxiety
_____Memory Loss
_____Psychiatric Disorders (please specify)______________________________________
____

_____Thick Toe Nails
_____Foot Ulcers
_____Rash
_____Other skin conditions (please specify) _____________________________________
____

_____Burning in Feet
_____Numbness in Feet
_____Tingling in Feet
_____Sciatica
_____Other neuropathic disorders (please specify) ________________________________
____

_____Thyroid Disease
_____Diabetes Controlled by ___diet ___pills ___insulin
_____Anemia
_____Blood Clots-Where: ___________________ Date: ______
_____Anticoagulants (blood thinners)
_____Cancer- Date: ____________Type: _____________________________
_____HIV

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I ________________________________ Date of Birth _________ hereby authorize West Coast Podiatry to use and disclose my **Protected Health Information (PHI)** in the manner described below. I understand that my PHI may be redisclosed by the person or entity receiving my PHI from this office and then may no longer be protected by federal privacy regulations. I voluntarily sign this authorization and I understand that my health care will not be affected if I do not sign this form. This form will remain in effect until I sign a new one or write a letter rescinding this one.

Permission to release my PHI: _______All records

Or Permission to release only: ______Chart Notes ______Test Results _____X-rays

Permission to release my PHI to: _____Only Medical requests

Or Permission to release to only: _____My Primary Care Physicians ____My Specialists _____Home Health ____ Physical Therapy Offices

You may also disclose my PHI to the following family members:

1. ____
2. ____

I also allow the employees of West Coast Podiatry to use my PHI to:

1. Remind me of future appointments
2. Report all future testing results. (To enclosed but not limited to MRI and CT results, Culture and Blood test results, X-ray reports and any communication from another treating provider.
3. To discuss my account balances and communicate the need for any further information that will help process my insurance claims.

I understand by checking the above boxes and signing this form that I give permission to use my PHI for the purposes of diagnosing, treatment and referrals. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying this office in writing. I understand that revocation or modification will have no bearing on my PHI sent before that time.

_________________________________ Patient signature

_______________ Date