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Dr. George J. Carioscia • Dr. Jessica Sullivan

WELCOME TO OUR OFFICE

NAME _____
LAST FIRST

ADDRESS _____
STREET APT # CITY STATE ZIP

HOME PHONE ( ) CELL PHONE ( ) EMAIL _____

AGE BIRTHDATE SOCIAL SECURITY #

SEX ☐ M ☐ F HEIGHT WEIGHT SHOE SIZE

YOUR OCCUPATION EMPLOYER

EMPLOYER'S ADDRESS

EMERGENCY CONTACT ( )
NAME PHONE

MARITAL STATUS ☐ S ☐ M ☐ W ☐ D NAME OF SPOUSE

DO YOU HAVE HEALTH INSURANCE? ☐ YES ☐ NO If yes, we'll need to copy your card(s).

IS IT *YOUR* POLICY? ☐ YES ☐ NO WHOSE POLICY IS IT? _____

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

GUARANTOR (RESPONSIBLE PARTY FOR THIS ACCOUNT OR CUSTODIAL PARENT) *complete if different than above*

NAME ( )
RELATIONSHIP PHONE

ADDRESS GUARANTOR'S SOCIAL SECURITY # GUARANTOR'S BIRTHDATE

GUARANTOR'S EMPLOYER ( )
NAME ADDRESS PHONE

* 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

WHAT IS YOUR FOOT PROBLEM? _____

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

BY WHOM?

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

MEDICAL INFORMATION

PAST MEDICAL HISTORY

Have you every had the following?

☐ Measles	☐ Cancer	☐ High Blood Pressure	☐ Psychological Problems
☐ Mumps	☐ Cataract	☐ Low Blood Pressure	☐ Seizure
☐ Chickenpox	☐ Cellulitis	☐ Hearing Loss	☐ Sexually Transmitted Disease
☐ Rheumatic Fever	☐ Circulatory Disorders	☐ Hepatitis _____	☐ Skin Problems
☐ AIDS or HIV+	☐ Diabetes	☐ Kidney Disease	☐ Stroke
☐ Anemia	☐ Digestion Problems	☐ Liver Disease	☐ Swelling of Feet/Ankles
☐ Arthritis	☐ Dizziness	☐ Migraine Headaches	☐ Tuberculosis
☐ Asthma	☐ Ear/Nose/Throat Problems	☐ Numbness/Tingling	☐ Thyroid Disease
☐ Balance Problems	☐ Epilepsy	☐ Pacemaker	☐ Ulcer Stomach/Skin
☐ Bladder Problems	☐ Fainting	☐ Pneumonia	☐ Varicose Veins
☐ Blood/Plasma Transfusions	☐ Fevers over 103°	☐ Polio	☐ Vision Problems
☐ Bowel Problems	☐ Heart Disease	☐ Prolonged Bleeding	☐ Other _____

Previous Hospitalizations/Surgeries/Serious Illness (and When?)

What medications and/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 THE CARE OF A PHYSICIAN? ☐ YES ☐ NO IF YES, FOR WHAT REASON(S)? _____

SOCIAL HISTORY

ARE YOU PREGNANT? ☐ 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 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: _____

_____

Please indicate any personal history below, check:

- **Constitutional Symptoms**
  - Good general health lately ☐ No ☐ Yes
  - Recent weight change ☐ No ☐ Yes
  - Fever ☐ No ☐ Yes
  - Fatigue ☐ No ☐ Yes
  - Headaches ☐ No ☐ Yes
- **Eyes**
  - Eye disease or injury ☐ No ☐ Yes
  - Wear glasses/contact lenses ☐ No ☐ Yes
  - Blurred or double vision ☐ No ☐ Yes
- **Ears/Nose/Mouth/Throat**
  - Hearing loss or ringing ☐ No ☐ Yes
  - Earaches or drainage ☐ No ☐ Yes
  - Sinus problem ☐ No ☐ Yes
  - Nose bleeds ☐ No ☐ Yes
  - Mouth sores ☐ No ☐ Yes
  - Bleeding gums ☐ No ☐ Yes
  - Bad breath or bad taste ☐ No ☐ Yes
  - Sore throat or voice change ☐ No ☐ Yes
  - Swollen glands in neck ☐ No ☐ Yes
- **Cardiovascular**
  - Heart trouble ☐ No ☐ Yes
  - Chest pain or angina ☐ No ☐ Yes
  - Palpitation ☐ No ☐ Yes
  - Shortness of breath w/exercise ☐ No ☐ Yes
  - Swelling of feet, ankles or hands ☐ No ☐ Yes
- **Respiratory**
  - Chronic or frequent coughs ☐ No ☐ Yes
  - Spitting up blood ☐ No ☐ Yes
  - Shortness of breath ☐ No ☐ Yes
  - Wheezing ☐ No ☐ Yes
- **Gastrointestinal**
  - Loss of appetite ☐ No ☐ Yes
  - Change in bowel movements ☐ No ☐ Yes
  - Nausea or vomiting ☐ No ☐ Yes
  - Frequent diarrhea ☐ No ☐ Yes
  - Painful bowel movements or constipation ☐ No ☐ Yes
  - Rectal bleeding or blood in stool ☐ No ☐ Yes
  - Abdominal pain ☐ No ☐ Yes
- **Genitourinary**
  - Frequent urination ☐ No ☐ Yes
  - Burning or painful urination ☐ No ☐ Yes
  - Blood in urine ☐ No ☐ Yes
  - Change in force or strain when urinating ☐ No ☐ Yes
  - Incontinence or dribbling ☐ No ☐ Yes
  - Kidney stones ☐ No ☐ Yes
  - Sexual difficulty ☐ No ☐ Yes
  - Male - testicle pain ☐ No ☐ Yes
  - Female - pain with periods ☐ No ☐ Yes
  - Female - irregular periods ☐ No ☐ Yes
  - Female - vaginal discharge ☐ No ☐ Yes
  - Female - # of pregnancies _____
  - Female - # of miscarriages _____
  - Female - date of last pap smear _____
- **Musculoskeletal**
  - Joint pain ☐ No ☐ Yes
  - Joint stiffness or swelling ☐ No ☐ Yes
  - Weakness of muscles or joints ☐ No ☐ Yes
  - Muscle pain or cramps ☐ No ☐ Yes
  - Back pain ☐ No ☐ Yes
  - Cold extremities ☐ No ☐ Yes
  - Difficulty in walking ☐ No ☐ Yes
- **Integumentary (skin, breast)**
  - Rash or itching ☐ No ☐ Yes
  - Change in skin color ☐ No ☐ Yes
  - Change in hair or nails ☐ No ☐ Yes
  - Varicose veins ☐ No ☐ Yes
  - Breast pain ☐ No ☐ Yes
  - Breast lump ☐ No ☐ Yes
  - Breast discharge ☐ No ☐ Yes
- **Neurological**
  - Frequent or recurring headaches ☐ No ☐ Yes
  - Light headed or dizzy ☐ No ☐ Yes
  - Convulsions or seizures ☐ No ☐ Yes
  - Numbness or tingling sensations ☐ No ☐ Yes
  - Tremors ☐ No ☐ Yes
  - Paralysis or weakness ☐ No ☐ Yes
  - Head injury ☐ No ☐ Yes
- **Psychiatric**
  - Memory loss or confusion ☐ No ☐ Yes
  - Nervousness ☐ No ☐ Yes
  - Depression ☐ No ☐ Yes
  - Insomnia ☐ No ☐ Yes
- **Endocrine**
  - Glandular or hormone problem ☐ No ☐ Yes
  - Excessive thirst or urination ☐ No ☐ Yes
  - Heat or cold intolerance ☐ No ☐ Yes
  - Skin becoming drier ☐ No ☐ Yes
  - Change in hat or glove size ☐ No ☐ Yes
- **Hematologic/Lymphatic**
  - Slow to heal after cuts ☐ No ☐ Yes
  - Bleeding or bruising tendency ☐ No ☐ Yes
  - Anemia ☐ No ☐ Yes
  - Phlebitis ☐ No ☐ Yes
  - Past transfusion ☐ No ☐ Yes
  - Enlarged glands ☐ No ☐ Yes

ALLERGIES

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

☐ Anesthetics ☐ Environmental Substances ☐ Pain Medication ☐ Sulfa
☐ Antibiotics ☐ Foods ☐ Penicillin ☐ Tape
☐ Aspirin ☐ Iodine ☐ Seasonal Allergies ☐ Tetanus
☐ Codeine ☐ IV Dye ☐ Silver ☐ Other _____

Specify above and any others _____

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 Doctors Carioscia, Esposito and Sullivan to diagnose and administer treatment of my foot condition.

SIGNATURE _____ DATE _____ REVIEWED BY _____

PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by Dr. Carioscia & Dr. Sullivan and its employees or designees. I authorize the physical health care services deemed necessary or advisable by my caregivers to address my needs. _____ INITIAL

CONSENT FOR PHOTOGRAPHS. I grant permission for photographs to be taken to assist in documenting my condition. _____ INITIAL

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION.
I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, of for the purposes of conducting the healthcare operations of the Practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Practice may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. _____ INITIAL

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE.
I authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to the Practice for an covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collecting including reasonable attorney's fees. _____ INITIAL

PRIVACY POLICY. I acknowledge having received the Practice's, "Notice of Privacy Policies." My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the Practice has already made disclosures with my prior consent. _____ INITIAL

PATIENT OR AUTHORIZED PERSON SIGNATURE RELATIONSHIP DATE

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