

BAY HARBOR PODIATRY GROUP

WELCOME TO OUR OFFICE!

Patient's Name _____ Email Address _____
Cell Phone # (____) _____
Home Phone # (____) _____ Work Phone # (____) _____

Home Address _____ **City** _____ **Zip** _____

Birthdate ___ / ___ / ___ Age ___ M ___ F ___ Single ___ Mar. ___ Div. ___ Wid. ___ Sep. ___

Preferred Language: English Spanish Japanese Chinese

Ethnicity _____ Race _____

Patient's Soc. Security # _____ - _____ - _____ Drivers License # _____

Patient's Occupation _____ Employer's Name _____

Employer Address _____ Phone # (____) _____

Who is Resp. for Health Insur. / Bills / Relation to Patient _____

Name of Spouse / Parent _____ **Birthdate of Spouse / Parent** ___ / ___ / ___

Spouse / Parent's Occupation _____ Spouse / Parent's Employer _____

Employer Address _____ Phone # (____) _____

Spouse's Social Security # _____ - _____ - _____ Spouse's D.L.# _____

Closest Relative or Emergency Contact NOT living with you _____

Address of Closest Relative _____ **Ph. No.** _____

Name and Address of Insurance Co. _____

ID # _____ Grp # _____ Ins. Co. Phone # (____) _____

Secondary Insurance Co. _____ Address _____

Secondary Ins. Co. Phone # (____) _____ ID # _____ Grp # _____

Family Physician Phone # (____) _____

Family Physician Name and address _____

Preferred Pharmacy: _____ **Location:** _____

Describe your Foot Problem _____

_____ Height _____ Weight _____ Shoe Size _____

How were you referred to our office? _____

I hereby give permission to Bay Harbor Podiatry Group, Marc G. Mittleman, D.P.M., and Associates, or whomever may be designated to: Photograph, administer treatment, and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY FINANCIAL OBLIGATION INCURRED DURING THE DIAGNOSIS AND/OR TREATMENT OF MY CONDITION.

Signature: _____

Date: _____

**ACKNOWLEDGMENT OF RECEIPT
of
NOTICE OF PRIVACY PRACTICES**

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 understand the Notice.

Patient Name _____

Date: _____

Parent or Authorized Representative (if applicable) _____

Signature _____

HEALTH QUESTIONNAIRE

Name _____

Date _____

Have you ever been informed by a doctor that you have:
(please circle)

- Arthritisyes no
- Gout.....yes no
- High Blood Pressure.....yes no
- Thyroid Trouble.....yes no
- Heart Trouble.....yes no
- Cancer.....yes no
- Poor Circulation.....yes no
- Neurological Problems..... yes no
- Diabetes.....yes no
- Stomach or Intestinal Ulcers.....yes no
- Hepatitis.....yes no
- Kidney or Liver Disease.....yes no
- Rheumatic Fever/Scarlet Fever.....yes no
- Skin Conditions (such as Psoriasis or Rash).. yes no

Breathing Problems (asthma, emphysema, tuberculosis (TB))..... yes no

Have You Ever Had a Blood Transfusion? Or Blood Borne Disease? yes no

Are you taking any medications now? (please list all) _____

Are you ALLERGIC to any medications or foods? (such as pain medications, antibiotics, sulfa, iodine, anesthetics, adhesive tape, others)

Prior Operations or Hospitalizations? _____

Traumatic Injuries or Broken Bones? _____

Any Complications from Childhood Diseases? _____

Any Serious or Life Threatening Infections? _____

When was your last physical exam? _____ Did you have an EKG? _____

Did you have a chest X-ray? _____ Were the findings normal? _____

Do you smoke? _____ If so, how much? _____

Do you drink alcohol? _____ If so, how much? _____

IS THERE ANY POSSIBILITY THAT YOU COULD BE PREGNANT? YES NO

Additional medical information: _____