ARAPIDIS Foot Care of Greater NY PC

FOOT AND ANKLE SPECIALIST & SURGEON

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Dr. Arapidis and his staff would like to WELCOME YOU! In order to serve you properly we need the following information. ALL information is strictly confidential. Please refer to our privacy policy for more information. If you need assistance, please do not hesitate to ask at the front desk.

PATIENTS NAME (Last, First, M.I.): ____

ADDRESS:____ ZIP:__________

Date of Birth:______________________ AGE:__________ GENDER: M , F

HOME PHONE:________________ **CELL:**________________ **WORK:**______________

SOCIAL SECURITY#:________________**EMAIL ADDRESS:**__________________________

EMERGENCY CONTACT: ____________________ PHONE #:________________________

EMPLOYER: __________________________ OCCUPATION:________________________

NAME OF INSURED **(if other than self)**:____________________________DOB:__________

INSURED'S HOME PHONE:_______________ CELL:______________ WORK:___________

PRIMARY HEALTH INSURANCE COMPANY:_______________________________________

MEMBER ID #:_________________________ GROUP #:___________________________

REFERRED BY: ____

PRIMARY CARE PHYSICIAN:___________________________PHONE #:_______________

GENERAL MEDICAL HISTORY: Do you have ANY medical conditions?______________________

____

____

LIST ANY MEDICATIONS YOU ARE TAKING (Including over the counter):____________________

____

____

PHARMACY NAME:_____________________________ PHONE #:____________________

LIST ANY PREVIOUS SURGERIES / HOSPITALIZATIONS (including dates):______________________

____

IF APPLICABLE DO YOU TAKE ANY ORAL CONTRACEPTIVES (birth control)?:___________________

LIST ANY ALLERGIES TO MEDICATIONS/DRUGS:____________________________________

LIST ANY ALLERGIES TO FOOD, SEAFOOD, IODINE, ADHESIVE TAPE, ETC.:__________________________

If Applicable: Are you, or are you trying to become pregnant? YES____ NO____

Do you smoke? YES / NO, Are you a past smoker? YES / NO, If yes how much? ______ Years? ________

Do you participate in any athletic activities? (Please list and indicate frequency):____________________

Do you wear over-the-counter-arch supports?____

Do you wear custom orthotics?_________ If yes, how old are they?______________________________

Have you ever experienced any recent weight change? _____________ Lbs.:________________________

Have you ever been to a Podiatrist before?____________________ Last visit?______________________

Have you had any previous or recent injuries/problems with your feet, ankles, knees, legs, lower back, spine?____

What is your weight?_________________ Height?_________________ Shoe Size?__________________

What is the **CHIEF COMPLAINT(S)** which brings you to my office for medical treatment? (Include foot, ankle, knee, thigh, and hip complaints):____

____

____

____

SYMPTOMS:

Which side? Right: ____ Left: ____ Both: ____

Type of Pain? Dull: ____ Burning: ____ Sharp: ____ Shooting: ____ Achy: ____ Pins & Needles: ____ Electricity: ____ Throbbing: ____

Duration: _________ Day(s) _________ Week(s) _________ Month(s) _________ Year(s) _________

When did you start having symptoms: ____

What aggravates your condition? Walking: _____ Standing: _____ Running: _____ After Rest: ______

At Rest: ____ Shoes: _____ Pain in a.m. /p.m. _____ Constant Pain: _____

Has pain/condition gotten: Worse: _____ Better: _____ Stayed the same: _____ Fluctuates: ____

Have you experienced this pain/condition in the past? (If yes, describe, including past treatment):_____

____

How long does the pain/condition last?:____

From a scale of 1(least) to 10(worst), how would you rate your pain/condition symptoms?___________

What have you tried to help yourself with your pain/condition symptoms?:_______________________

Additional Comments: ____

____

<u>Consent</u>: I certify that to the best of my knowledge the information that I provided above is true and correct. I give permission to Dr. Arapidis to administer treatment/procedures that are deemed necessary in the diagnosis/treatment of the conditions/symptoms of my feet/ankles.

Patient's/Guardian's Signature:_____________________________________Date:____________________

<u>Assignment and Release of Benefits Information and Authorization:</u> I understand that the doctor's office will bill my insurance company as a courtesy and that I am financially responsible for all charges for services rendered to me, whether or not paid by my insurance, including copayments, deductibles and non-covered services. I authorize my insurance benefits to be paid directly to the doctor. I authorize the release of any information necessary to process my claim(s). I acknowledge that I have received a copy of notice of privacy practices which describes the use and disclosure of my protected health information. IF NOT SIGNED PAYMENT IS DUE AT TIME OF SERVICE. I authorize the use of this signature on all insurance submissions. ALL CO-PAYMENTS DUE ON DAY OF SERVICE.

Patient's/Guardian's Signature:_____________________________________Date:____________________