This information is confidential

Office Use Only EHS Pt. # ________________

PATIENT INFORMATION

Name ______________________________

Address ______________________ Apt. # _____

City ______________________________

State __________________ Zip ____________

Telephone (________) ____________________

Cell Phone (________) ____________________

E-mail: ______________________________

Social Security # ________________________

Date of Birth ____/ _____/ ______ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Veteran: ☐ Yes ☐ No

Race: ☐ Asian ☐ Black or African ☐ White
☐ Hispanic/Latino ☐ American Indian
☐ Alaska Native ☐ Hawaiian Native

Preferred Language: ☐ English ☐ Spanish ☐ Italian
☐ French ☐ German ☐ Chinese ☐ Sign Language
☐ Arabic ☐ Japanese ☐ Other

Occupation ______________________________

Employer ______________________________

Address ______________________________

____

Work Phone ____________________ Ext. __________

Spouse Information (if applicable)

Name ______________________________

Home Phone ______________________________

Work Phone ____________________ Ext. __________

Out-of-State Address (if different)

Address ______________________________

City ______________________________

State __________________ Zip ____________

Telephone (_______) ______________________

Is this the address you receive your Social Security benefits?:

☐ Yes ☐ No

INSURANCE INFORMATION

Primary - Ins. Co. Name ______________________

Policyholder Name: ______________________

☐ Self ☐ Spouse

Policy Holders Date of Birth ____/ ____/ ____

Employer ______________________________

Secondary - Ins. Co. Name ______________________

Policyholder Name: ______________________

☐ Self ☐ Spouse

Policy Holders Date of Birth ____/ ____/ ____

Employer ______________________________

PHARMACY INFORMATION

Pharmacy Name ______________________

Address ______________________________

City ______________________ State ________

EMERGENCY CONTACT (If other than spouse)

Name ______________________________

Relationship: ______________________________

Telephone (_______) ______________________

Complete only if patient is under age 18

(Responsible Party Information)

Name ______________________________

Address ______________________________

City ______________________________

State __________________ Zip ____________

Telephone (____) ______________________

SS# ____________________ DOB ____________

Occupation ______________________________

Employer ______________________________

Address ______________________________

Work Phone (____)____________________ Ext. ________

PLEASE COMPLETE REVERSE SIDE OF FORM

Office Use Only EHS Pt. # ________________

Is your treatment today due to:

.... a work related injury ☐ Yes ☐ No Injury Date ________________

Do you have written authorization from your employer and comp carrier to be treated? ☐ Yes ☐ No

.... a motor vehicle accident ☐ Yes ☐ No Accident Date ________________

.... an accident / liability case ☐ Yes ☐ No Accident Date ________________

Whom may we thank for sending you to our office?

☐ Doctor ________________

☐ Patient ________________

☐ Newspaper: ( ) Bradenton Herald ( ) Sarasota Herald Tribune

☐ Other ________________

____

☐ Verizon Yellow Pages (Please check which book below)
☐ Bradenton ☐ Sarasota ☐ Sun City ☐ Beaches

☐ Our Website ☐ Health Fair

☐ Living on the Suncoast ☐ Passed By Location

☐ Insurance Provider List

I hereby authorize the release of any medical information pertaining to my treatment or information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignments. This authorization will remain valid until revoked by me in writing. I understand that I am legally responsible for all charges whether or not reimbursed by my insurance company.

Signature **X** ________________ Date ________________

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Cortez Foot & Ankle Specialists** for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA-1500 form, or else where on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT’S NAME (Please Print)		PROVIDER: Name, Address and Zip
		Cortez Foot & Ankle Specialists
PATIENT'S SIGNATURE		**Dr. Richard N. Berkun, D.P.M.**
		Dr. Christopher J. Addison, D.P.M.
PATIENT’S MEDICARE NO.	DATE	**Dr. Robert D. Katz, D.P.M.**
		Dr. Philip J. Baldinger, D.P.M.
		Dr. Garrett L. Harte, D.P.M.
		Dr. Scott A. Handley, D.P.M.

Name: ________________________ Date: __________

EHS Patient #: ________________________ Age: __________

Case #: ________________________

Referred By: ____________________
Former Podiatrist: ____________________
Last Seen: ____________________
Insurance: ____________________

History & Medical Information

1. **Primary Care Physician:** ________________________

   Address: ________________________ Last Visit (date) __________

2. **Explain your foot/ankle problem:** ________________________ ☐ left ☐ right

3. **When did pain/discomfort begin (date):** ________________________

   Describe pain/discomfort: ☐ burning ☐ numbness ☐ sharp ☐ other ____________

4. **Has condition been treated?** ☐ yes ☐ no

5. **Past Medical History:**

	☐ Gout	☐ Kidney Disease	☐ Other Arthritis
☐ Anemia	☐ Heart Disease	☐ Lung Disorders	☐ Prostate Disorders
☐ Bleeding Disorders	☐ Hepatitis	☐ Mitral Valve Prolapse	☐ Rheumatic Fever
☐ Cancer	☐ High Cholesterol	☐ Nerve Disorders	☐ Thyroid Disorders
☐ Diabetes	☐ HIV/Aids	☐ Neurologic	☐ Stroke
☐ Epilepsy	☐ High Blood Pressure	☐ Osteoarthritis	☐ Other __________

6. **List all medications/herbs/vitamins:** ☐ **NONE**

   ____

7. **Allergies:** (Describe reaction that occurred) ☐ **NONE**

☐ Penicillins	☐ Aspirin	
☐ Narcotic Agent/Codeine	☐ Anesthesia	☐ Shellfish
☐ Sulfa Drugs	☐ Radiographic Contrast/Dye	☐ Other __________

8. **Surgical History:** (Last 5 Years)

   Have you had surgery: ☐ Yes - if yes, describe below ☐ No

   Surgery / Date: ________________________

   ____

9. **Social History:** (Only check what is pertinent to you)

☐ Tobacco Use	☐ Alcohol Use	☐ Exercise habits __________
☐ Caffeine Use	☐ Drug use (recreational, IV)	

10. **Occupation/Job:** ________________________

11. **Family History:** (List relationship of family member(s) who have had these problems):

☐ Diabetes	☐ Heart Disease	☐ Bleeding Disorders	☐ Mental Illness
☐ High Blood Pressure	☐ Stroke	☐ Kidney Disease	☐ Cancer
☐ Rheumatology	☐ Other Family History: __________		

12. **Additional** Information: ________________________

Please fill in the following information:

HEIGHT: __________ feet __________ inches **WEIGHT:** __________ pounds

Do Not Fill In Office Use Only: Blood Pressure ______/______ Date __________

Name: ________________________________ Date: __________

EHS Patient#: ____________________________ Age: __________

Cortez Foot & Ankle Specialists
Review of Systems

Please check any of the following that you are **currently experiencing** or have **recently experienced**

1. **Constitutional Symptoms:**
☐ fever ☐ chills ☐ sweats ☐ weight loss ☐ **None**

2. **Head, eyes, ears, nose and throat:** Do you…
Wear: ☐ contacts ☐ dentures ☐ eyeglasses ☐ **None**
Have: ☐ double vision ☐ cataracts ☐ dizziness ☐ ringing in ears
☐ difficulty swallowing ☐ neck pain ☐ sore throat
☐ nosebleeds ☐ **None**

3. **Cardiovascular** (Heart and Blood Vessels):
☐ chest pain, heart attack ☐ congestive heart failure ☐ heart murmur ☐ palpitations
☐ swelling in legs/ankles ☐ leg pain w/exercise ☐ cardiovascular surgery ☐ **None**

4. **Hematological/Lymphatic** (Blood) History of:
☐ bleeding abnormalities ☐ anemia ☐ lump in groin or armpit ☐ lymphoma
☐ swollen glands ☐ **None**

5. **Respiratory:**
☐ shortness of breath ☐ emphysema ☐ cough ☐ bronchitis
☐ difficulty breathing ☐ wheezing ☐ asthma ☐ previous pulmonary disease
☐ TB (tuberculosis) exposure or treatment ☐ pneumonia ☐ **None**

6. **Gastrointestinal** (Stomach and Intestinal Tract) History of: ☐ abdominal pain
☐ nausea ☐ vomiting ☐ diarrhea ☐ constipation
☐ decrease in appetite ☐ blood in stool ☐ hepatitis ☐ **None**

7. **Endocrine:**
☐ often thirsty ☐ often urinating ☐ kidney disease ☐ pancreatitis
☐ diabetes mellitus ☐ prostate problems ☐ thyroid disorder ☐ **None**

8. **Musculoskeletal** (Bones and Joints):
☐ tendonitis ☐ bursitis ☐ broken bones ☐ Arthralgia
☐ weakness of limbs ☐ feeling weak ☐ inflammatory condition, joint pain
☐ **None**

9. **Nervous System** History of:
☐ migraines ☐ seizures ☐ strokes ☐ nervous disorders
☐ ataxia (loss of balance) ☐ aphasia (loss of speech) ☐ confusion/disorientation ☐ fainting
☐ neuropathy (loss of sensation) ☐ speech difficulties ☐ **None**

10. **Integumentary** (Skin):
☐ rash ☐ skin ulcers ☐ lesions ☐ sensitivity to the sun
☐ change in skin color ☐ growth on the skin ☐ recurrent infections ☐ cracking of the skin
☐ eczema ☐ keloid ☐ hair loss ☐ **None**

11. **Allergic, Immunologic** History of:
☐ dermatitis ☐ any sensitivities ☐ lupus ☐ rheumatoid arthritis
☐ other autoimmune disease (please list): ________________________________ ☐ **None**

12. **Psychiatric** History of:
☐ nervousness ☐ tension ☐ depression ☐ **None**