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 _____

_____

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

☐ Our Website ☐ Passed By Location

☐ Health Fair

☐ 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 **Dr. Richard N. Berkun, D.P.M.** **Dr. Christopher J. Addison, D.P.M.** **Dr. Robert D. Katz, D.P.M.** **Dr. Philip J. Baldinger, D.P.M.** **Dr. Garrett L. Harte, D.P.M.** **Dr. Noelis Rosario, D.P.M.** **Dr. Michelle Emery, D.P.M.**
PATIENT'S SIGNATURE		
PATIENT'S MEDICARE NO.	DATE	

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:**

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

Cortez Foot & Ankle Specialists
Review of Systems

EHS Patient#: _____ Age: _____

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**