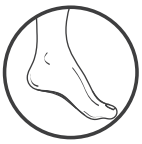


PARK AVENUE PODIATRIC CARE

Emanuel Sergi, DPM

PODIATRIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date: _____ SS/HIC/Patient ID#: _____

Patient Name: _____
Last Name First Name Middle Initial

Address: _____ City: _____ State: _____

Zip: _____ Email: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ Years

Patient Employer / School: _____

Employer / School Address: _____

Employer / School Phone: (__) _____

Spouse's Name: _____ Birthdate: _____ SS# _____

Spouse's Employer: _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____ Relationship to Patient: _____

Insurance Co.: _____ Group #: _____ Is patient covered by additional insurance? Yes No

Subscriber's Name: _____ Birthdate: _____ SS#: _____

Relationship to Patient: _____ Insurance Co.: _____ Group #: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with: _____
Name of Insurance Company

and assign directly to Dr. _____ all Insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

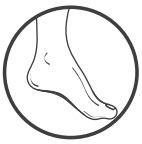
MEDICARE / MEDIGAP AUTHORIZATION

I request payment of authorized Medicare benefits and, if applicable, Medigap benefits be made either to me or on my behalf to: _____ for any service furnished to me by that provider. To the extent
Name of Doctor of Clinic

permitted by law, I authorize any holder of medical or other information about me to release to the center for Medicare and Medicaid services, my Medigap Insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ _____
Signature of Beneficiary, Guardian or Personal Representative Please Print Name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary



PARK AVENUE PODIATRIC CARE

Emanuel Sergi, DPM

PODIATRIC REGISTRATION AND HISTORY

3 PHONE NUMBERS

Home Phone: (__) _____ Cell Phone: (__) _____ Best time and place to reach you: _____

IN CASE OF EMERGENCY, CONTACT

Name: _____ Relationship: _____

Home Phone: (__) _____ Work Phone: (__) _____

4 PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

Have you ever been to a Podiatrist before? Yes No If yes, please list: Name: _____ Last Visit: _____

Is there any personal or family history of diabetes? Yes No Your occupation: _____

Cigarette / Tobacco use: _____ Years Smoked: _____

Athletic activities in which you participate (please list and indicate frequency.)

_____

_____

_____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	☐ Yes ☐ No		Foot or Leg Cramps	☐ Yes ☐ No	
Athlete's Foot	☐ Yes ☐ No		Heel Pain	☐ Yes ☐ No	
Bunions	☐ Yes ☐ No		Ingrown Toenails	☐ Yes ☐ No	
Corns and Calluses	☐ Yes ☐ No		Plantar Warts	☐ Yes ☐ No	
Cramps or Numbness in Feet or Legs	☐ Yes ☐ No		Swelling in Ankles or Feet	☐ Yes ☐ No	
Flat Feet	☐ Yes ☐ No		Tired Feet	☐ Yes ☐ No	

5 MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS / HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Rash	☐ Yes No
Allergies to Anesthetics	☐ Yes ☐ No	Eye Problems	☐ Yes ☐ No	Respiratory Disease	☐ Yes No
Allergies to Medicine or Drugs	☐ Yes ☐ No	Fainting	☐ Yes ☐ No	Rheumatic Fever	☐ Yes No
Anemia	☐ Yes ☐ No	Foot or Leg Cramps	☐ Yes ☐ No	Shortness of Breath	☐ Yes No
Angina	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Sinus Problem	☐ Yes No
Arthritis	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Special Diet	☐ Yes No
Artificial Heart Valves or Joints	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Stroke	☐ Yes No
Asthma	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Swelling in Ankles, Feet	☐ Yes No
Back Problems	☐ Yes ☐ No	Hepatitis or Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes No
Bleeding Disorders	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Tired Feet	☐ Yes No
Cancer	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Tuberculosis	☐ Yes No
Chemical Dependency	☐ Yes ☐ No	Liver Diseases	☐ Yes ☐ No	Ulcers	☐ Yes No
Chest Pain	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Varicose Veins	☐ Yes No
Chronic Diarrhea	☐ Yes ☐ No	Neuropathy	☐ Yes ☐ No	Venereal Disease	☐ Yes No
Circulatory Problems	☐ Yes ☐ No	Phiebitis	☐ Yes ☐ No	Weight Loss, Unexplained	☐ Yes No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
Ear Problems	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		

Surgeries you have had: _____

_____

_____

Hospitalization other than for the surgeries listed: _____

_____

_____

PARK AVENUE
PODIATRIC CARE

Emanuel Sergi, DPM

PODIATRIC REGISTRATION AND HISTORY

(section 5 continued)

Family Physician: _____ Last Visit Date: _____

Are you now, or have you been, under any doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain: _____

6 MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins: _____

Pharmacy Name(s): _____ Pharmacy Phone(s): (___) _____

Do you take oral contraceptives? ☐ Yes ☐ No

7 ALLERGIES

☐ Adhesive / Tape	☐ Codeine	☐ Local Anesthetics	☐ Seafoods
☐ Anticoagulant Therapy	☐ Demerol	☐ Novocaine	☐ Sulfa
☐ Aspirin	☐ Iodine	☐ Penicillin	

Other: _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please Print Name of Patient, Parent Guardian or Personal Representative — Relationship to Patient