



Johanna S. Youner, DPM, FACFAS

Emanuel Sergi, DPM

PODIATRIC REGISTRATION AND HISTORY

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: (____) _____

Spouses Name: _____ Birthdate: _____ SS# _____

Spouse's Employer: _____

Whom may we thank for referring you? _____

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: _____
 Name of Doctor of Clinic

for any service furnished to me by that provider. To the extent 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



Johanna S. Youner, DPM, FACFAS

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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Foot or Leg Cramps | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Athlete's Foot | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heel Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bunions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ingrown Toenails | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Corns and Calluses | <input type="checkbox"/> Yes <input type="checkbox"/> No | Plantar Warts | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cramps or Numbness in Feet or Legs | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling in Ankles or Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Flat Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tired Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No |

5 MEDICAL HISTORY

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

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

Surgeries you have had: _____

Hospitalization other than for the surgeries listed: _____



PARK AVENUE
PODIATRIC ASSOCIATES

Johanna S. Youner, DPM, FACFAS

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

- | | | | |
|--|----------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Adhesive / Tape | <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Seafoods |
| <input type="checkbox"/> Anticoagulant Therapy | <input type="checkbox"/> Demerol | <input type="checkbox"/> Novocaine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Penicillin | |

Other: _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (an 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