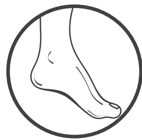


PARK AVENUE
PODIATRIC CARE

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

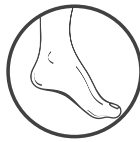
I request payment of authorized Medicare benefits and, if applicable, Medigap benefits be made either to me or on my behalf to: ______________________________ for any service furnished to me by that provider. To the extent
Name of Doctor of Clinic
permitted by law, I authorize any holder of medical or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

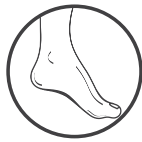
____

____

Hospitalization other than for the surgeries listed: ______________

____

____



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