NORTHWEST PODIATRY CENTER, LTD.

G.C. BRYNICZKA, DPM, – A.W. BRYNICZKA, DPM , - D.W. O'BRIAN, DPM, - M. ZEMELA, DPM

WELCOME: Thank you for choosing Northwest Podiatry Center for your foot care needs. Below are questions to help us get better acquainted and provide information vital to your health. Please feel free to discuss matters of a private nature with the doctor. This information will be kept confidential.

PATIENT INFORMATION

NAME: (LAST)_____ (FIRST)_____ (M.I.)_____

ADDRESS:_____ CITY:_____ ST:_____ ZIP:_____-_____

HOME PHONE#:_____ WORK PHONE#:_____ CELL PHONE#:_____

MAY WE E-MAIL INFORMATION TO YOU? □ NO □ YES EMAIL ADDRESS_____

MAY WE TEXT INFORMATION TO YOU? □ NO □ YES

BIRTH DATE:_____ AGE:_____ SOCIAL SECURITY#:_____ □ MALE □ FEMALE

EMPLOYER:_____ EMPLOYER ADDRESS:_____ OCCUPATION:_____

Race:_____Ethnicity:_____ HT:_____ WEIGHT:_____SHOE SIZE:_____

□ SINGLE □ MARRIED □ WIDOWED □ SEPARATED □ DIVORCED

Is there a family member or other person you would like us to release medical information to: _____

RELATIONSHIP TO PATIENT:_____ PHONE# (_____)_____

IF PATIENT IS A MINOR (under 18)

FATHER NAME: Last_____First_____M.I. _____ MOTHER NAME: Last_____First_____M.I____

ADDRESS:_____ ADDRESS:_____

CITY:_____ ST:_____ ZIP:_____ CITY:_____ ST:_____ ZIP:_____

HOME PHONE#_____ CELL PHONE#_____ HOME PHONE#_____ CELL PHONE#_____

INSURANCE INFORMATION

IS THIS A WORK RELATED INJURY? □ YES □ NO CLAIM# _____ ADJUSTER INFORMATION_____

YOUR PRIMARY INSURANCE CO.:_____ ID#_____ GROUP#_____

NAME OF POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____

POLICY HOLDERS DATE OF BIRTH _____ POLICY HOLDERS SS# _____

CO-PAY: □ YES □ NO AMOUNT OF CO-PAY: $_____

DO YOU HAVE SECONDARY INSURANCE? □ YES □ NO

NAME OF SECONDARY INSURANCE COMPANY:_____ ID#_____ GROUP#_____

NAME OF POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____

POLICY HOLDERS DATE OF BIRTH _____ POLICY HOLDERS SS# _____

OFFICE VISIT INFORMATION

WHAT BRINGS YOU TO THE OFFICE TODAY _____

HOW LONG HAS IT BOTHERED YOU? □ DAYS □ WEEKS □ MONTHS □ YEARS

ANY PAST PROBLEMS WITH YOUR FEET OR ANKLES? □ YES □ NO PLEASE DESCRIBE_____

HOW WERE REFERRED TO OUR OFFICE? _____

□ YELLOW PAGES □ INSURANCE DIRECTORY □ INTERNET AD □ FRIEND □ PATIENT □ DOCTOR □ RELATIVE

****PLEASE COMPLETE *ALL* INFORMATION ON *BOTH* SIDES OF FORM *****

MEDICAL INFORMATION

WOULD YOU LIKE YOUR PODIATRIC REPORT SENT TO YOUR MEDICAL DOCTOR? □ YES □ NO

FAMILY DOCTOR NAME:_____ _____ LAST VISIT:_____

ADDRESS:_____ PHONE# (_____)_____FAX#(_____)_____

PHARMACY
NAME_____Phone_____Fax_____

PHARMACY
ADDRESS_____

ARE YOU TAKING ANY MEDICATIONS? □ YES □ NO PLEASE PROVIDE LIST OR FILL IN BELOW

NAME OF MEDICATION	DOSAGE

ARE YOU ALLERGIC TO: □ ASPIRIN □ BETADINE (IODINE) □ CODEINE □ IBUPROFEN □ PENICILLIN □ SULFA □ TAPE OR BAND-AID □TYLENOL
□ OTHER: _____ □ **NO KNOWN DRUG ALLERGIES**

DO YOU HAVE OR HAVE YOU HAD A PROBLEM WITH ANY OF THE FOLLOWING? □ **NONE**

□ Angina	□ Anemia	□ Asthma	□ Back Problems	□ Bronchitis
□ Cancer	□ Cardiac Disease	□ Chronic Renal Disease	□ Cirrhosis	□ Coma
□ Congestive Heart Failure	□ Convulsion / Seizures	□ COPD	□ Diabetes/ High Sugar	□ Emphysema
□ Heart Murmur	□ Heart Attack	□ Hiatal Hernia	□ HIV / AIDS	□Hypercholesterolemia
□ Hyperlipidemia	□ Hypertension	□ Irregular Heartbeat	□ Kidney Disease	□ M.I.
□ Obesity	□ Osteoarthritis	□ Osteoporosis	□ Peripheral Vascular Disease	□ Pneumonia
□ Palpitations	□ Polio	□ Recent Cold	□ Rheumatic Fever	□ Rheumatoid Arthritis
□ Stroke	□ Sleep Apnea	□ Thyroid Disease	□ Tuberculosis	□ Liver Disease
□ Jaundice	□ GERD	□ Fibromyalgia	□ Blood Clot	□ Other

HAVE YOU HAD ANY SURGICAL PROCEDURES OTHER THAN FOOT OR ANKLE? □ YES □ NO
IF YES PLEASE DESCRIBE: _____

DO YOU HAVE ANY ARTIFICIAL JOINTS? □ YES □ NO

DO YOU HAVE A HEART VALVE IMPLANT? □ YES □ NO

SOCIAL HISTORY:

DO YOU SMOKE? □ 1/2 PACK PER DAY □ 1 PACK PER DAY □ 1 1/2 PACKS PER DAY + □ NEVER SMOKED

ARE YOU A FORMER SMOKER □ NO □ YES IF YES WHEN DID YOU QUIT SMOKING? _____

DO YOU USE RECREATIONAL DRUGS □ NO □ YES

DO YOU DRINK? □ NO □ SOCIALLY □ 1 DRINK PER DAY □ 2 DRINKS PER DAY+

FAMILY HISTORY:
MOTHER _____
FATHER _____
BROTHER _____
SISTER _____

IS THERE A FAMILY HISTORY OF BLOOD CLOTS? □ YES □ NO

PATIENT SIGNATURE: _____ **DATE:** _____

GUARDIAN SIGNATURE: _____ **RELATIONSHIP: □ MOTHER □ FATHER □ OTHER**