Douglas M. Finkel, D.P.M / VENICE ARCADIA PODIATRY, INC.

□ Douglas M. Finkel, D.P.M. P.A.
Brielle L. Roggow D.P.M P.A

Office# (941) 488-0222
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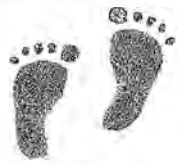

PLEASE FILL OUT ALL 3 FORMS COMPLETELY

Name_____ Birth Date_____ Todays Date_____

Address_____ City_____ ST_____ Zip_____
(No PO Box Please)

Home Phone #_____ Cell Phone #_____

Northern Address_____ City_____ ST_____ Zip_____

List dates you reside up north: From:_____ To:_____ Northern Phone # _____

Email Address: _____

MEDICAL HISTORY - Check only the items that apply.

☐ Anemia	☐ Charcot Joint	☐ Heart Disease	☐ Liver Disease
☐ Arthritis	☐ CVA - Stroke	☐ High Blood Pressure	☐ Neuropathy
☐ Asthma	☐ Diabetes - Insulin Y N	☐ High Cholesterol	☐ Peripheral Vascular Disease
☐ Autoimmune Disease	☐ Epilepsy	☐ Hypothyroidism	☐ Rheumatic Fever
☐ Blood Clots	☐ Gastric Reflux / GI Ulcers	☐ Kidney Disease	☐ Varicose Veins
☐ Cancer	☐ Gout	☐ Leg Cramps	☐ Vision Problems
			☐ HOSPICE

SURGICAL HISTORY - Check only the items that apply.

☐ Angioplasty leg / heart	☐ Heart By-Pass	☐ Kidney	
☐ Arterial By-Pass	☐ Hernia Repair	☐ Open Heart	☐ **OTHER:**
☐ Back / Spine	☐ Hip Replacement	☐ Pacemaker	☐
☐ Carotid Artery	☐ Hysterectomy	☐ Prostate	☐
☐ Cataract	☐ Knee Replacement	☐ Venous Ligation	☐

FAMILY HISTORY - Check if a family member had any of the following.

Mother	☐ Diabetes	☐ Cancer - Type:	☐ Heart Disease or HBP
Father	☐ Diabetes	☐ Cancer - Type:	☐ Heart Disease or HBP
Brother / Sister	☐ Diabetes	☐ Cancer - Type:	☐ Heart Disease or HBP

Please List or give us a copy.

_____ _____
_____ _____
_____ _____

☐ Aspirin	☐ Sulfa
☐ Penicillin	☐ Codeine
☐ Novocaine	☐ Other:
☐ Latex / Adhesive Tape	☐ NONE

SOCIAL HISTORY - Check only the items that apply.

☐ Alcohol	☐ Occasional Alcohol	☐ Tobacco	☐ Caffeine
Amt. per day_____		Amt. per day_____	Amt. per day_____

REVIEW OF SYMPTOMS - Check only those that apply.

HEAD & NECK	EAR, NOSE & THROAT	GASTROINTESTINAL	CARDIOVASCULAR
☐ Dizziness	☐ Hoarseness	☐ Jaundice	☐ High Blood Pressure
☐ Headaches	☐ Hearing Loss	☐ Hepatitis	☐ Chest Pain
☐ Double Vision	☐ Infection	☐ Abnormal Stools	☐ Murmurs or MVP
☐ Infection	☐ Sores	☐ Cramping	☐ Edema
RESPIRATORY	**MUSCULOSKELETAL**	**NEUROLOGICAL**	☐ Ulceration
☐ Asthma	☐ Joint Pain or Swelling	☐ Paralysis	☐ Phlebitis
☐ Bronchitis	☐ Muscle Pain	☐ Stroke	
☐ Emphysema	☐ Weakness	☐ Tics or Tremors / Seizures	
	HEIGHT:_____	**WEIGHT:**_____	**SHOE SIZE:**_____

For Office Use Only

PVD - YES / NO Response Date:
NEURO – YES / NO Response Date:
PCP: _____ Code(s) _____

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Social Security Number: _____

	Employer Status:		Marital Status:		Race:		Preferred Language:
	Retired		Divorced		America Indian /Alaskan Native		English
	Full Time		Legally Separated		Asian [A]		Spanish
	Part Time		Single		Black [B]		Other:
	Not Employed		Unknown		Caucasian [C] / White		
			Widowed		Other [E]		
			Married		Pacific Islander [P]		
			Spouse's Name:				
					Hispanic		
					Non-Hispanic		
					Decline to Answer		

Nursing Station / Caretaker Phone # _____

Person Responsible for Payment: _____ Phone # _____

Please provide a Picture ID and your Insurance Cards for photo-copying, to be placed in your chart.

Referred By_____

I certify that the information given by me in the applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security administration or its intermediates or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original document. I request payment of the authorized benefits payable for physician or organization furnishing the services or authorize such physician or organization to submit to Medicare for payment to me. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignment. (Lifetime Signature)

Signature _____ *Print Name:* _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT.
Our office safeguard's your protected health information. We are committed to the privacy & confidentiality of your health information whether created by us or maintained on our premises.
We are required by state & federal regulations to implement policies & procedures to safeguard the privacy of your health information. We are required by state and federal regulations to abide by the privacy practices described in this notice including any future revisions that we may make to the notice that become necessary or authorized by law. Individual identifiable information about your past, present, or future health provisions of health care to you, or payment for the health care treatment or services you receive is considered protected health information.
We are required to provide you with this Privacy Notice that contains information regarding our privacy practices that explains how, when & why we may use or disclose your protected health information and your rights and our obligations regarding any such uses or disclosures. Except in specified circumstances, we must use or disclose only the minimum necessary protected health information to accomplish the intended purpose of the use or disclosure of such information. We reserve the right to change this notice at any time and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future about you. Should we revise/change the Privacy Notice, we will post a copy of the new/revised Privacy Notice in our office. You may also request and obtain a copy of any new/revised Privacy Notice from our Privacy Practice Manager Wendy Ross. We use and disclose protected health information for a variety of reasons. We have a limited right to use and/or disclose your health information for purposes of providing your supplies, payment, or for the operations of our company. For other uses, you must give us your permission and written authorization to release your protected health information unless the law permits or requires us to make the use or disclosure without your authorization. Should it become necessary to release your protected health information to an outside party, we will require the party to have a signed agreement with us that the party will extend the same degree of privacy protection to your information as we do. The privacy law permits us to make some uses or disclosures of your protected health information without your consent or authorization. If you would like the complete copy of the HIPAA Notice, please ask at the front desk.

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Arcadia Podiatry Inc.

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Name _____

PRIMARY CARE PHYSICIAN

DATE LAST SEEN: _____

PHYSICIAN NAME: _____

ADDRESS: _____

PHONE #: _____ FAX #: _____

CARDIOLOGIST

DATE LAST SEEN: _____

PHYSICIAN NAME: _____ PHONE #: ( ) _____

ADDRESS: _____ FAX #: ( ) _____

NEUROLOGIST

DATE LAST SEEN: _____

PHYSICIAN NAME: _____ PHONE #: ( ) _____

ADDRESS: _____ FAX #: ( ) _____

ENDOCRINOLOGIST

DATE LAST SEEN: _____

PHYSICIAN NAME: _____ PHONE #: ( ) _____

ADDRESS: _____ FAX #: ( ) _____

PHARMACY NAME: _____

LOCATION: _____

NOTES: _____