FOOT CARE CENTERS OF PALM BEACH

IRA SPINNER, D.P.M.
ABFAS Board Certified

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10075 Jog Rd. Suite 208
Boynton Beach, FL 33437

Name_____ Date of Birth _____ Age_____

Home Address_____City/Zip_____

Phone_____ Cell_____ Email: _____

Occupation_____ Name of Husband/Wife/Guardian _____

Primary Insurance_____#_____Secondary Insurance_____#_____

Primary Care Physician: _____ Telephone Number: _____

Other Physicians involved in your healthcare: _____

How did you hear about us? _____

Reason for you visit today: _____

Date of onset: _____

Pharmacy: _____ Pharmacy Number: _____

MEDICATIONS: Please list current medications/dosage/frequency:

_____

_____

_____

_____

_____

_____

Allergies: _____

_____

I authorize the release of medical information necessary to process this claim also payment to government benefits either to myself or to the party who accepts assignment.

Date: _____ Signature:_____

Habits:

Alcohol: o None o Yes: How many drinks / day _____ frequency / week ___ What kind_____

Tobacco: o None o Yes: Chew or Smoke _____ How many / day ____ Since _____

Caffeine: o None o Yes: What kind _____ How many / day_____

Family History (Please indicate deceased or alive, medical issues and age):

Father: _____ Mother: _____

Past Surgical History (indicate date if known):

o None

o Cataracts _____

o Tonsillectomy_____

o Thyroidectomy_____

o Adenoidectomy _____

o Coronary Bypass _____

o Cardiac Stents _____

o Pacemaker _____

o Heart Valve _____

o Gall Bladder_____

o Appendectomy_____

o Bowel/Stomach _____

o Hemorrhoidectomy _____

o Mastectomy _____

o Lumpectomy _____

o Bariatric _____

o Hysterectomy _____

o Endoscopy _____

o Colonoscopy _____

o Hernia _____

o Spinal_____

o Bladder_____

o Prostate _____

o Orthopedic / Joints_____

o Hip _____

o Knee_____

o Foot _____

o Cancer _____

o Heart Stent _____

o Leg Stent_____

o _____

o _____

Past Medical History:

Head Aches	❑ Yes	❑ No	Date: _____
Stroke	❑ Yes	❑ No	_____
Seizures	❑ Yes	❑ No	_____
Diabetes (Type 1 or Type 2)	❑ Yes	❑ No	_____
Thyroid Disease (Low or High)	❑ Yes	❑ No	_____
High Blood Pressure	❑ Yes	❑ No	_____
Blood Clots	❑ Yes	❑ No	_____
❑ Pulm Emboli (lung clots)	❑ Yes	❑ No	_____
❑ DVT (leg clots)	❑ Yes	❑ No	_____
Heart Burn, Reflux	❑ Yes	❑ No	_____
Stomach Ulcers	❑ Yes	❑ No	_____
Heart Disease	❑ Yes	❑ No	_____
❑ Coronary Disease	❑ Yes	❑ No	_____
❑ MI / Heart Attacks	❑ Yes	❑ No	_____
❑ Congestive Heart Failure	❑ Yes	❑ No	_____
❑ Atrial Fibrillation	❑ Yes	❑ No	_____
❑ Angina	❑ Yes	❑ No	_____
❑ Valve Disorder	❑ Yes	❑ No	_____
High Cholesterol	❑ Yes	❑ No	_____
Gastrointestinal Bleeding	❑ Yes	❑ No	_____
Hepatitis (A, B, C)	❑ Yes	❑ No	_____
Chronic Wounds	❑ Yes	❑ No	_____
Cancer (type)	❑ Yes	❑ No	_____
Incontinence	❑ Yes	❑ No	_____
Frequent Urination	❑ Yes	❑ No	_____
COPD (Emphysema, Bronchitis)	❑ Yes	❑ No	_____
Asthma	❑ Yes	❑ No	_____
Depression	❑ Yes	❑ No	_____
Anxiety	❑ Yes	❑ No	_____
Fibromyalgia	❑ Yes	❑ No	_____
Arthritis	❑ Yes	❑ No	_____
Gout	❑ Yes	❑ No	_____
Osteoporosis	❑ Yes	❑ No	_____
Prostate Disease	❑ Yes	❑ No	_____
Breast Disease	❑ Yes	❑ No	_____
Frequent Bowl Movement	❑ Yes	❑ No	_____
Parkinsons	❑ Yes	❑ No	_____
Neuropathy	❑ Yes	❑ No	_____

Review of Symptoms ✔ Yes or Now for Symptoms in the Past 6 Months (Circle) for Symptoms TODAY:

Constitutional / Endocrine:

❑ Yes	❑ No	Fever
❑ Yes	❑ No	Chills
❑ Yes	❑ No	Weakness / Fatigue
❑ Yes	❑ No	Weight Loss
❑ Yes	❑ No	Weight Gain
❑ Yes	❑ No	Insomnia
❑ Yes	❑ No	Snoring
❑ Yes	❑ No	Excessive Thirst
❑ Yes	❑ No	Excessive Urination
❑ Yes	❑ No	Cold or Heat Intolerance

Other: _____

HEENT:

❑ Yes	❑ No	Sore Throat
❑ Yes	❑ No	Stiff Neck
❑ Yes	❑ No	Change in Your Voice
❑ Yes	❑ No	Sinus Drainage
❑ Yes	❑ No	Sinus Head Ache
❑ Yes	❑ No	Nose Bleeds
❑ Yes	❑ No	Ear Ache / Drainage
❑ Yes	❑ No	Hearing Loss
❑ Yes	❑ No	Ringing in Your Ears
❑ Yes	❑ No	Blurred Vision / Loss
❑ Yes	❑ No	Wear Glasses or Contacts
❑ Yes	❑ No	Itchy / Watery Eyes
❑ Yes	❑ No	Dental Problems

Other: _____

Gastrointestinal:

❑ Yes	❑ No	Nausea / Vomiting
❑ Yes	❑ No	Difficulty Swallowing
❑ Yes	❑ No	Hemorrhoids
❑ Yes	❑ No	Diarrhea
❑ Yes	❑ No	Constipation
❑ Yes	❑ No	Bloody or Black Stools
❑ Yes	❑ No	Abdominal Pain
❑ Yes	❑ No	Heartburn / Indigestion
❑ Yes	❑ No	Frequent Use of Laxatives

Other: _____

Urinary:

❑ Yes	❑ No	Pain or Burning with Urination
❑ Yes	❑ No	Urinary Frequency (night or day)
❑ Yes	❑ No	Blood in Urine / Dark Urine
❑ Yes	❑ No	Incontinence
❑ Yes	❑ No	Slow Starting or Stopping Urine

Other: _____

Cardiac:

❑ Yes	❑ No	Chest Pain
❑ Yes	❑ No	Palpitation
❑ Yes	❑ No	Irregular Heartbeat
❑ Yes	❑ No	Exercise Intolerance
❑ Yes	❑ No	Leg Swelling

Other: _____

Respiratory:

❑ Yes	❑ No	Persistent Cough
❑ Yes	❑ No	Coughing Up Blood
❑ Yes	❑ No	Shortness of Breath
❑ Yes	❑ No	Wheezing
❑ Yes	❑ No	Can't Breathe Laying Flat

Other: _____

Skin:

❑ Yes	❑ No	Rashes / Hives
❑ Yes	❑ No	Skin Discoloration
❑ Yes	❑ No	Lesions / Moles / Warts
❑ Yes	❑ No	Ulcers
❑ Yes	❑ No	Itching
❑ Yes	❑ No	Nail Problems
❑ Yes	❑ No	Unusual Hair Loss
❑ Yes	❑ No	Easy Bruising

Other: _____

Psych:

❑ Yes	❑ No	Depressed Mood
❑ Yes	❑ No	Suicidal Thoughts / Plans
❑ Yes	❑ No	Agitation / Irritability
❑ Yes	❑ No	Insomnia
❑ Yes	❑ No	Anxiety
❑ Yes	❑ No	Frequent Crying Spells

Other: _____

Musculoskeletal:

❑ Yes	❑ No	Joint Pains or Stiffness
❑ Yes	❑ No	Joint Swelling
❑ Yes	❑ No	Muscle Weakness
❑ Yes	❑ No	Back Pain
❑ Yes	❑ No	Muscle Spasms / Cramps
❑ Yes	❑ No	Falling

Other: _____

Neurologic:

❑ Yes	❑ No	Frequent Headache
❑ Yes	❑ No	Seizures
❑ Yes	❑ No	Syncope (passing out)
❑ Yes	❑ No	Limb Weakness
❑ Yes	❑ No	Limb Numbness
❑ Yes	❑ No	Dizziness
❑ Yes	❑ No	Swallowing Difficulty
❑ Yes	❑ No	Balance Issues
❑ Yes	❑ No	Tremors
❑ Yes	❑ No	Rigidity

Other: _____

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CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that if I want to receive treatment from one or more of the health care providers, ("Providers") associated with this Practice; I need to give permission for them to share information about my health, among themselves and with other individuals for treatment, billing purposes and other health care operations. I also understand that all reasonable efforts will be made to protect the privacy of my health information, whether it is maintained on paper or electronically, and regardless of the method by which it is communicated.

By signing below, I agree that any of the Providers associated with this practice may:

1. Use my health information, on a need to know basis, to give me treatment.
2. Share my health information with others who are involved with my treatment either in or outside of this practice.
3. Use my health information for billing purposes.
4. Share my health information with health insurance companies, government agencies, or other payors that request information related to benefits, claims filed, and other billing matters.
5. Share my health information either in or outside of this practice for health care operations that include evaluation of the quality of health care services your receive, and of the performance of the Providers to find better ways to provide care.
6. Share my health information with outside parties ("Business Associates") who contract with the practice to perform medical services on behalf of our patients. (ie: lab, radiology, night nurse triage, or for nebulizer equipment release)

Additionally, the Practice will generate Health Assessment Forms at annual physical examinations which provide information on current health and immunization status. These Forms will be given to me for my personal use and any further disclosure of this information I choose to make is at my personal discretion.
I understand that the Practice has a "Notice of Privacy Practices" ("Notice") that describes in detail (1) how my health care information is used and shared, (2) when I need to give further approval for the Providers to use and share my health information, (3) when my permission is not needed for the Providers to use and share my health information, (4) my rights regarding my health care information, and (5) grievance procedures if I believe my privacy rights have been violated. I understand that I may request restrictions on the uses and disclosures of my health information. The Practice is not legally required to accept my request, but if it does, it will put any such restrictions in writing and abide by them except in emergency situations, or where required by law.

I understand that I have the right to receive a copy of the Notice and that I have the right to read the Notice before signing this Consent. I understand that Foot Care Centers of Palm Beach reserves the right to change the Notice at any time. I may obtain a current copy of the Notice by contacting the Practice at (561) 734-4876.

I understand that I may revoke this consent, in writing, except to the extent that the Providers have already acted on it. I also understand that if I revoke this consent, the Providers have the right to refuse to provide further treatment to me.

I consent to the uses and disclosure of my health information as described above.

Signature of Patient or Legal Guardian_____

Print Name: _____Date:_____