JAWS podiatry
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**PLEASE PRINT CLEARLY**

FIRST/*NOMBRE*_____MI_____LAST/*APELLIDO*_____

ADDRESS/*DIRECCIÒN*_____SUITE/APT_____

CITY/*CUIDAD*_____STATE/*ESTADO*_____ZIP/*CÒDICOPOSTAL*_____

E-MAIL ADDRESS _____

HOME/*CASA*: (  ) _____-_____WORK/*TRABAJO*: (  ) _____-_____

CELL/*CELULAR: (*  ) _____-_____DATE OF BIRTH/*FECHA DE NACIMIENTO*_____

SOCIAL SECURITY/ *NÙMERO SOCIAL* #: _____--_____-- _____

FAMILY PHYSICIAN/*MÈDICO DE CABECERA* _____

PHONE/*TELÈFONO* (  ) _____-_____

WHO MAY WE THANK FOR THIS REFERRAL? _____

¿QUIÈN LO REMITIO USTED A NUESTRA OFICINA? _____

MARITAL STATUS/ ESTADO CIVIL:

SINGLE/*SOLTERO(A)* MARRIED/*CASADO(A)* *DIVORCED*/*DIVORCIADO(A)* WIDOWED/*VIUDO(A)* PARTNERSHIP/ *PAREJA*

EMERGENCY CONTACT/*CONTACTO DE EMERGENCIA* _____

PHONE/*TELÈFONO* (  ) _____-_____

EMPLOYER/*EMPLEADOR*: _____

I hereby authorize my insurance company to pay directly to Jeffrey Galitz, MD, DPM, PA any and all medical and/or surgical fees otherwise payable to me for their professional services.
I acknowledge that I am personally responsible and liable to Jeffrey Galitz, MD, DPM, PA, for any and all surgical and/or medical fees billed by them. Should Jeffrey Galitz, MD, DPM, PA accept payment directly from my insurance company; I understand that I am responsible and liable for any and all deductible/co-pay expenses for the insurance company. If in the event Jeffrey Galitz, MD, DPM, PA are required to retain the services of an attorney/collection agency to collect his bills I agree to pay Jeffrey Galitz, MD, DPM, PA's fees up through and including appellate fees.
A copy of our office's Privacy Practices is available from the front desk upon request.

Por la presente autorizo a mi compañía de seguros a pagar directamente a Jeffrey Galitz, MD, DPM, PA cualquier y todos los gastos médicos y / o quirúrgicos de otro modo pagadero a mí por sus servicios profesionales.
Reconozco que soy personalmente responsable y obligado a Jeffrey Galitz, MD, DPM, PA, de cualquier y todos los honorarios quirúrgicos y / o médicos facturados por ellos. En caso de Jeffrey Galitz, MD, DPM, PA aceptar el pago directamente de mi compañía de seguros, yo entiendo que soy responsable y responsable por cualquier y todos los gastos deducibles / co-pago de la compañía de seguros. Si en el caso de Jeffrey Galitz, MD, DPM, PA están obligados a contratar los servicios de una agencia de abogado / colección para recoger sus cuentas Acepto pagar Jeffrey Galitz, MD, DPM, PA, honorarios de DPM arriba hasta e incluyendo los honorarios de apelación.
Una copia de las prácticas de privacidad de nuestra oficina está disponible en la recepción bajo petición.

SIGNATURE/ *FIRMA* _____ DATE/ *FECHA* _____

**PATIENT HISTORY**

*** Please fill out all forms to the best of your ability. The staff will go over the form and answer any questions you may have.**

Full Name: _____ Height: _____ Weight: _____

**1)** What is the main problem with your feet or ankles? _____

**2)** When did you FIRST notice the condition? _____

**3)** Is this an injury? ____Yes ____No If Yes, when did it occur? _____/_____/_____

If Yes, did it happen at work? __Yes __No Are you claiming Workman's Comp? __Yes __No

**4)** Check all of the following that apply:

**Type of Pain** __Burning __Tingling __Sharp __Dull Ache __Throbbing __Shooting __Stabbing

**When Painful** ___Upon Standing __During Walking __After Walking __During Sports

__Worse with Activity __Better as Activity Continues ___Worse when standing __With Shoes __Without Shoes ___A.M ___P.M

___Lying in Bed ___Always

**5)** How painful is your condition? If **0** = "no pain" and **10** = "the worst pain you have ever experienced", please circle your pain level: **0**

**1 2 3 4 5 6 7 8 9 10**

**6)** Have you had foot care before? __Yes __No By whom and when: _____

**SURGICAL HISTORY**

| Procedure or Hospitalization | Date | Complications |
|---|---|---|
| | | |
| | | |
| | | |

**MEDICATIONS (**Please list all current prescription, over the counter, and supplements you are taking)

| Medication | Dosage | How Often | Medication | Dosage | How Often |
|---|---|---|---|---|---|
| 1. | | | 4. | | |
| 2. | | | 5. | | |
| 3. | | | 6. | | |

Pharmacy: _____ Number: _____-_____-_____

**MEDICAL HISTORY**

Please place a **CHECK MARK** next to which of the following you suffer from and if indicated, please write in the space following what type.

| | | | |
|---|---|---|---|
| Anemia | | Foot Deformity | |
| Arthritis | | Frost Bite | |
| Artificial Joint | | Gout | |
| Asthma | | HIV/AIDS | |
| Back Pain | | Headaches/Migraines | |
| Bleeding Disorder | | Heart Disease | |
| Blood Clots | | Hepatitis | |
| Cancer | | Hernia | |
| Coronary Artery Disease | | Hypertension | |
| DVT | | Kidney Disease | |
| Diabetes | | Leg/foot ulcer | |
| Dialysis | | Liver Disease | |
| High Cholesterol | | Lung Disease | |
| Swelling | | Organ Transplant | |
| Fibromyalgia | | Osteoporosis | |
| Pacemaker | | Seizures/Epilepsy | |
| Peripheral Vascular Disease | | Stroke | |
| Polio | | Substance Abuse | |
| Pulmonary Embolism | | Thyroid Problems | |
| Raynaud's Disease | | Tuberculosis | |
| Rheumatoid Arthritis | | Varicose Veins | |

**SOCIAL HISTORY**

Do you drink alcohol? ____Yes ____No; If yes, how much? □ 1-2 per week □ 5-6 per week □ > 3 per day

Recreational drug use

* Any type of drug use is a personal choice and will in no way adversely effect your relationship with the doctor. However, many drugs can interact with other medications and treatments with potential life threatening effects. Therefore, it is extremely important that you answer honestly. Your response will be held in the most strict patient-doctor confidentiality.

Answer: ____Yes ____No

If Yes: What substance and how often used? _____

What is your occupation? _____

What is your marital status? □Married □Single □Divorced □Separated □Widow □Partner

Do you smoke tobacco? ____Yes ____No

If Yes: _____ # of years smoking? _____Packs per day? ____Cigarettes per day?

If No: Did you ever smoke? ____Yes ____No

If you quit: How long ago did you stop smoking? _____

**FAMILY HISTORY** *** Please check all that apply**

| | Diabetes 1 or 2 | Heart Disease | Hypertension | Gout | Cancer and Type | Age of Death |
|---|---|---|---|---|---|---|
| **Father** | | | | | | |
| **Mother** | | | | | | |
| **Brother** | | | | | | |
| **Sister** | | | | | | |

**ALLERGIES** Please list all allergies and the types of reactions you have:

_____

Primary Care Physician: _____Phone: _____
Approximate date of last physical exam ____/____/____

Which other physicians would you like us to share a copy of your visit with?

_____

□ Diabetes; What is the name and phone number of the doctor treating you for Diabetes?

_____

When was your last visit? ____/____/____ What is your average blood sugar reading? _____

Are you pregnant? ____Yes ____No How many weeks? _____

**REVIEW OF SYSTEMS** □ **I am not experiencing any of the below symptoms.**

*If you are experiencing any of the following please check the appropriate boxes

**General:** □Fever □Night Sweats □Weight Gain ____Lbs □Weight Loss ____Lbs
**Eyes:** □Glasses □Contacts □Double vision □Blurred vision □Blindness □Cataracts
**Ears**: □Decreased or loss of hearing □Ringing in the ears □Chronic earaches
**Nose:** □Nose bleeds □Sinusitis P
**Mouth/Throat**: □Sore throat □Bleeding gums □Snoring □Dry mouth □Teeth Problems
**Cardiovascular:** □Chest pain □Shortness of breath when walking □Palpitations □Murmurs
□Heart valve disease □Leg cramps
**Respiratory:** □Cough □Wheezing □Shortness of breath □Coughing up blood □Sleep apnea
**Gastrointestinal:** □Nausea □Vomiting □Diarrhea □Constipation □Bloody stool □Loss of appetite □Acid Reflex
**Genitourinary:** □Chronic kidney or bladder infections □Difficulty urinating □Pain with urination □Dark or bloody urine
**Musculoskeletal:** □Muscle Aches □Weakness □Joint Pain □Back pain □Leg swelling □Difficulty walking □Frequent falls
**Skin:** □Abnormal Mole □Rash □Dry skin
**Neurologic:** □Loss of consciousness □Tingling/Numbness □Seizures □Dizziness □Headaches
**Psychiatric:** □Depression □Sleep difficulties
**Endocrine:** □Fatigue □Heat intolerance □Cold intolerance □Hair loss
**Hematological:** □Easy bruising □Excessive bleeding

**NOTICE OF PRIVACY PRACTICES (HIPAA REGULATIONS)**

☐ You were provided with a document entitled "Notice of Privacy Practices." It is required by governmental regulations that all medical facilities provide you with this notice. Please check the box to acknowledge that you have read (or had the opportunity to read if you chose) and understand the notice. This is a copy of the notice that is yours to keep. If you do not want the copy, simply return it to the receptionist with your other materials.

**CONSENT**

I certify that the information above is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures, including therapeutic and diagnostic injections, as may be deemed necessary in the diagnosis and/or treatment of my feet.

**Signature: _____ Date: _____/_____/_____**

**FSOA 08/20/08**

RELEASE OF INFORMATION

PATIENT NAME: _____

(Print Name)

I hereby grant permission to _____ to disclose/ or

release any and all information conserning my illness and/ or treatment to

_____

_____ _____

Patient / Guardian Signature Witness Signature


**Photo and Promotional Release Form**

I hereby consent to be interviewed, recorded, photographed, videotaped or filmed by representatives of JAWS healthcare for purposes of publication, display or broadcast (print, web, digital display and all other forms of media).

I agree that such interviews, recordings, articles, quotes, photographs, films, audio or video and/or any reproductions of same in any form, are the property of JAWS healthcare, and I relinquish any present or future claim for reimbursement for said photographic or film reproduction of my likeness or for said testimonials by me.

I hereby release JAWS healthcare, its affiliates, employees, representatives and agents from any and all claims, demands, costs and liability that may arise from the use of these interviews, recordings, photographs, videotapes or films, and/or any reproductions of same in any form, as described above, arising out of being interviewed, recorded, photographed, videotaped or filmed.

I acknowledge that I have read this consent form in its entirety, or it has been read (or translated) to me, and I have had the opportunity to ask questions about it and understand it.

Date: _____

Name (print): _____

Signature: _____

*Parent or Legal Guardian name (print):
_____

*Parent or Legal Guardian signature:
_____

Witness: _____

*Parent or Legal Guardian name and signature required for individuals under age 18