

Welcome to Broderick Podiatry

Name: _____ Date of Birth: ____/____/____
Last First Middle Initial

Home Phone Number: _____ Mobile Number: _____

Home Address: _____
Street City State Zip Code

Primary Health Insurance: _____/#_____
Insurance Company Name ID Letters and Number

Subscriber Name (ex. Spouse, Parent) and Date of Birth: _____/
Name DOB

Secondary Health Insurance: _____/#_____
Insurance Company Name ID Letter and Number

Subscriber Name (ex. Spouse, Parent) and Date of Birth: _____/
Name DOB

Primary Care Physician: _____ Last seen (approx.): _____

Have you ever seen a podiatrist before? Yes No

Reason: _____

How did you hear about us? _____

Chief Complaint: _____

Prior Treatment: _____

Height: _____ Weight: _____ Shoe Size: _____ Recent BP: _____

Date of Vaccines:

Influenza: _____ Pneumonia: _____ Shingles (Varicella): _____ Tetanus: _____

MEDICAL HISTORY:

Diabetes:	YES	NO
Hypertension:	YES	NO
Cancer:	YES	NO
Stroke:	YES	NO
Convulsions:	YES	NO
Stomach Ulcers:	YES	NO
Hepatitis (A, B or C):	YES	NO
Liver Disease:	YES	NO
Arthritis	YES	NO
Gout:	YES	NO
Backaches:	YES	NO
Heart Disease:	YES	NO
Heart Murmur:	YES	NO
Rheumatic Fever:	YES	NO
Asthma:	YES	NO
Tuberculosis:	YES	NO
Anemia:	YES	NO
Other: _____	YES	NO

ALLERGY/IMMUNOLOGY:

Latex:	YES	NO
Codeine:	YES	NO
Iodine/Shellfish:	YES	NO
Penicillin:	YES	NO
Sulfa Antibiotics:	YES	NO
Aspirin/Related:	YES	NO
Morphine/Related:	YES	NO
Novocain/Related:	YES	NO
Tetanus Toxins:	YES	NO
Other: _____		

SOCIAL HISTORY:

Marital Status:	Not Married/Married
Tobacco Use:	Yes/No/Former Smoker
Alcohol Use:	Never/Moderate/Daily
Drug Use:	Yes/No/Former Drug User

Do you currently have an infection? YES NO

Signature

Date

Patient Name

Please list any past surgeries: _____

CURRENT MEDICATIONS:

(If you have a list of your medicines, you can skip this and we can make a copy.)

NAME OF MEDICATION	DOSAGE	# OF TIMES A DAY

**ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have been provided a copy of or offered the opportunity to receive of James Broderick, DPM a notice of Privacy Practices.

As stated in our Privacy Practices, we may disclose to a member of your family, a relative, a close friend, or any other person you identify your protected health information that directly relates to that person's involvement in your health care. We request that you designate the individuals that we may discuss your protected health care information. We may also disclose or request your medical information to or from your primary care physician.

I, _____, give James Broderick, DPM and/or his colleagues' permission to discuss my protected health information with my primary care physician as well as the following person(s):

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____