21ST CENTURY FOOTCARE, P.C.

"To Your Health, One Step at a Time"

Vito J. Rizzo, DPM, DABFAS

Omer F. Aci, DPM. FAPWCA

PATIENT INFORMATION			
First Name:	Middle Name:	Last Name:	
Social Sec.#:	Date of Birth: / /	Age:	Sex: M F
Home Address:			
City:	State:	Zip Code:	Email:
Home Phone: ( )	Cell Phone: ( )	Work Phone :( )	
Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino Other: _____ Race: ☐ White ☐ African American ☐ American Indian ☐ Native Hawaiian ☐ Asian Other: _____			
Preferred Language: English ☐ Spanish ☐ Other: _____	Marital Status: S M D W	Driver License #:	
Occupation:	Employer:		
Employer Address:			
Primary Physician:	Phone: ( )		
Last Medical Visit: / /	Referred by:		

IN CASE OF EMERGENCY CONTACT	
Last Name:	First Name:
Relationship:	Phone :( )

PREFFERED PHARMACY			
Name of Pharmacy:	Phone: ( )		
Address	City:	State:	Zip Code:
May we contact your pharmacy for medication list? Yes No			

INSURANCE INFORMATION		
Primary Insurance:		
Name of Insured:	DOB: / /	Relationship:
Member ID #:	Phone: ( )	
Secondary Insurance:		
Name of Insured:	DOB: / /	Relationship:
Member ID #:	Phone: ( )	

I the undersigned, authorize Dr _____ to examine and treat my feet medically, surgically, or biomechanically. I hereby assign my insurance benefits to be paid directly to 21st Century FootCare P.C. and I am responsible for any unpaid balance. I authorize the release of any medical information necessary to process all claims.

Acknowledgment of Receipt of Notice of Privacy Practices:

I Acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

SIGNATURE: _____ DATE: _____

GUARDIAN'S SIGNATURE: _____ RELATION: _____

IF PATIENT IS A MINOR (UNDER 18) OR UNABLE TO SIGN OWN CONSENT

Name: _____ **Chart #:**_____

MEDICAL HISTORY

WHAT BROUGHT YOU TO SEE THE DOCTOR? (Please provide a brief description of the nature of the illness / injury.)
WHEN DID YOUR SYMPTOMPS BEGIN?
WHAT TREATMENTS HAVE YOU TRIED?
WHAT OTHER FOOT/ANKLE/LEG PROBLEMS DO/DIDYOU HAVE?

ALLERGIES: Do you have any allergies?	1.	2.	3.

MEDICATIONS: What medications are you currently taking?

1.	6.	11.	16.
2.	7.	12.	17.
3.	8.	13.	18.
4.	9.	14.	19.
5.	10.	15.	20.

PAST MEDICAL HISTORY

Please indicate whether you have had any of the following medical problems:

	Yes	No		Yes	No
Heart Disease			Arthritis		
Heart Valve Replacement			Gout		
Heart Attack			Fibromyalgia		
Chest Pain			Osteoporosis		
Pacemaker			Leg Pain		
High Blood Pressure			Back Pain		
High Cholesterol			Weakness In Extremities		
Stroke			Numbness In Extremities		
Shortness Of Breath			Balance Problems		
Lung Disease			Dizziness		
Asthma			Headaches/Migraines		
Sleep Apnea			Changes/Loss Of Vision		
Liver Disease			Stomach Ulcer		
Hepatitis			Tuberculosis		
Bleeding Disorder			HIV		
Clotting Disorder			Cancer *(What Type?)*		
Anemia			Thyroid Condition		
DVT (Blood Clot)			Pregnant		
Kidney Disease			Diabetes Type I __Type II __		
Fractures *(When/Where?)*					
Joint Replacement *(Which?)*			Skin Conditions *(What Kind?)*		

Other(S): *(Please specify)*

FAMILY HISTORY

Please check if any of your family members have / had any of the following:

	Yes	No		Yes	No
Bleeding Disorder			Gout		
Cancer			Arthritis		
Heart Trouble			Bunion		
High Cholesterol			Bunionette		
High Blood Pressure			Flat Feet		
Stroke			High Arched Feet		
Diabetes			Pigeon-Feet		

Other*(Please specify):*

SOCIAL HISTORY

	Yes	No	what kind, how much, & how often?
Do you smoke?			
Did you ever smoke?			
Caffeine? *(tea /coffee)*			
Alcohol use? *(Currently using or used in the past)*			
Illicit drug use?			
Do you exercise regularly?			

PAST SURGICAL HISTORY

Procedure	Date	Surgeon	Complication
1.			
2.			
3.			
4.			

HEIGHT: _____ **WEIGHT:** _____ **SHOE SIZE:** _____

I certify that to the best of my knowledge that the information provided is true and accurate and I have disclosed all pertinent medical history.

SIGNATURE OF PATIENT(OR GUARDIAN): _____ DATE: _____