Welcome to Broderick Podiatry

Name: _____ **Date of Birth:** ___/___/___
Last **First** **Middle Initial**

Gender: M / F **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? Primary Physician **/** Family / Friend / Online / Newspaper / Website

Chief Complaint: _____

Prior Treatment: _____

Height: _____ **Weight:** _____ **Recent Blood Pressure:** _____**Tetanus Vaccine:** _____

MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY):
Diabetes High Blood Pressure Shortness of Breath Rheumatic Fever Stomach Ulcer

Difficulty healing when cut Heart Disease Gout Cancer Stroke Hepatitis Other_____

ALLERGY/REACTION TO ANY OF THE FOLLOWING? (PLEASE CIRCLE ALL THAT APPLY):
Cortisone Penicillin Latex Codeine Novocain Adhesive Tape Aspirin Morphine Iodine

Marital Status: please circle one: Single Married Domestic Partner Separated Divorced Widowed

I hereby give my permission to James E. Broderick, DPM to administer treatment and to perform minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition.

_____
SIGNATURE DATE

_____

Patient Name

Please list any past surgeries: _____

_____

_____

Which pharmacy would you like prescriptions sent to? _____

CURRENT MEDICATIONS:

(If you have a list of your prescriptions, 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 will also disclose or request your medical information to or from your primary care physician,** but please include any other physicians you would like us to share information with.

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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____