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 / Newspaper / Website

Chief Complaint: _____

Prior Treatment: _____

Height: _____
Weight: _____
Recent Blood Pressure: _____
Date of Tetanus Vaccine: _____

MEDICAL HISTORY:

Diabetes Type 1	YES	NO
Diabetes Type 2:	YES	NO
Hypertension:	YES	NO
Cancer:	YES	NO
Stroke:	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: _____
_____

Do you currently have an infection?	YES	NO

ALLERGY/IMMUNOLOGY:

Cortisone	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
Codeine	YES	NO
Latex	YES	NO

SOCIAL HISTORY:

	_____
Marital Status:	Yes/No
Tobacco Use:	Never/Moderate/Daily
Alcohol Use:	Yes/No/Former Drug User
Drug Use:	

_____ _____
Signature **Date**

_____

Patient Name

Please list any Major surgeries:

_____

_____

PHARMACY/LOCATION: _____

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, (**sign name**) _____, 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) as emergency contact:**

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