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**

SOCIAL HISTORY:

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

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