



NORTH FLORIDA FAMILY PODIATRY CENTER, PA

Medical & Surgical Foot Specialist

609 5th Street SW, Suite 4 • Live Oak, FL 32064 • 386-362-2555

www.floridapodiatry.net

Today's Date: _____

Last Name	First	Middle Int.	Age	Birth Date
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Mailing Address

City	State	Zip
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Home Phone	Cell Phone	E-mail
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Marital Status Married Single Divorced Separated Widow/er Minor Sex: Male Female

Patient or Parent Driver's License #	SS#
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Employed By	Occupation	Work Phone
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Spouse/Parent Name

In case of emergency, contact	Phone
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Referral: Whom may we thank for referring you to our office?

How did you learn about our office: Yellow Pages Website Insurance Book Other

PAYMENT METHOD: Cash Check Credit Card Medicare Insurance

PRIMARY INSURANCE COMPANY:

Name of Insured	SS#	Date of Birth
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Relationship to Patient	Employed By
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Work Address/City/Zip	Work Phone
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SECONDARY INSURANCE COMPANY:

Name of Insured	SS#	Date of Birth
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Relationship to Patient	Employed By
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Work Address/City/Zip	Work Phone
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Family physician	Phone	Last visit
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MEDICAL RELEASE: I assign the right to payment for all medical benefits directly to North Florida Family Podiatry Center in consideration for medical services and supplied provided pursuant to my health insurance plan. In the event my health insurance plan refuses to pay for provided medically necessary services, I also assign all of the ERISA rights to Dr. Bruce Ornstein for a full and fair review of any and all denied claims. This ERISA assignment is in consideration for the unpaid services provided and in consideration for the continued willingness of Dr. Bruce Ornstein to see patients, including myself on an insurance assignment basis. I understated that if my treating doctor prevails in any such payment dispute, I may be liable for co-payment for the contested services. I give consent to release medical information to Dr. Bruce Ornstein. I give consent to Dr. Bruce Ornstein to release medical information to other health care providers for the purpose of treatment, when necessary for my care. I give consent to Dr. Bruce Ornstein to send medical information, as necessary, to my insurance plan. ERISA is an acronym for the Employee Retirement Income Security Act. The Employee Retirement Security Act includes federal laws requiring insurance companies to process submitted insurance claims and appealed (denies) insurance claims according to ERISA regulations. The failure to process submitted insurance claims and appealed (denies) insurance claims according the ERISA regulations may result in fines charged to the insurance company in amounts up to \$100 a day for each infraction.

Printed Name: _____ Patient Signature: _____ Date: _____



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HEALTH HISTORY QUESTIONNAIRE

Date _____

Name _____ Birth Date _____

Family Physician _____ Phone _____ Last Visit _____

CHIEF COMPLAINT AND HISTORY: Please describe for what we are seeing you.

APPX. WHEN DID THIS CONDITION BEGIN? _____

HAVE YOU PREVIOUSLY SEEN A PODIATRIST? Yes No

IF SO, WHEN AND FOR WHAT? _____

PAST MEDICAL HISTORY: List any medical conditions you may have _____

PAST SURGICAL HISTORY: List any surgeries you may have had _____

CURRENT MEDICATIONS:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Additional Meds: _____

CURRENT ALLERGIES: Please check all that apply.

Penicillin Novocaine Sulfa Iodine Aspirin None

Other-please list: _____

SOCIAL HISTORY:

Tobacco: packs per day _____ How many years? _____ When did you quit _____

Alcohol: how often and how much each week? _____

Job Description: Mostly standing Mostly sitting Mix of both Retired

I hereby give Drs. Bruce Ornstein permission to examine and treat me.

Patient, Parent or Guardian's Signature _____

REVIEW OF SYSTEMS: Have you had or are you currently having any of the following?

GENERAL	Current	Past	DIGESTIVE	Current	Past
HEAD. EYES. EARS			Heartburn?		
Frequent Headaches?			Vomiting?		
Dizziness?			Constipation?		
Ringling in Ears?			Diarrhea?		
Change in Hearing?			Black Stools?		
Sore Throat?			Blood with Stools?		
Trouble Swallowing?			CARDIOVASCULAR		
Blurred/Double Vision?			Chest Pain?		
Poor Vision and/or Wear Glasses?			High Blood Pressure?		
RESPIRATORY			Use Oxygen at Home?		
Frequent Colds?			Pacemaker?		
Difficulty Breathing?			Swelling in Ankles/Legs?		
Cough • Productive?			Other?		
Asthma/Hay Fever?			MUSCLE, BONE, JOINTS		
Emphysema?			Leg Pain - at rest?		
Other?			Leg Pain - walking?		
NEUROLOGICAL			Back Pain?		
Change in Memory?			Joint Aching/Pain?		
Trouble with Balance?			Swelling of Joints?		
Change in Sensation?			Difficulty with Joint Motion?		
Where?			Other?		
Other?			SKIN		
BLADDER / KIDNEY			Rash?		
Frequent Urination?			New Growths/Lumps?		
Burning on Urination?			Color Change in Mole or Wart?		
Blood in Urine?			Skin Cancer?		
Difficulty with Urination?			Other?		
Other?					

COMMENTS: _____

Reviewed By: **Bruce Ornstein, D.P.M.** Date: _____