COASTAL FOOT CARE SERVICES, INC.
NEW PATIENT INFORMATION FORM

PATIENT INFORMATION:

LAST NAME:	**FIRST NAME:**		**MI:**	
ADDRESS:	**APT. #:**	**CITY:**	**STATE:**	**ZIP:**
DATE OF BIRTH:	**MOBILE NUMBER:**	**HOME PHONE:**		
SOCIAL SECURITY #:	**MARITAL STATUS:** **MARRIED** **SINGLE** **OTHER**			

EMERGENCY CONTACT INFORMATION:

LAST NAME:		**FIRST NAME:**		
ADDRESS:	**APT. #:**	**CITY:**	**STATE:**	**ZIP:**
EMERGENCY PHONE NUMBER:				

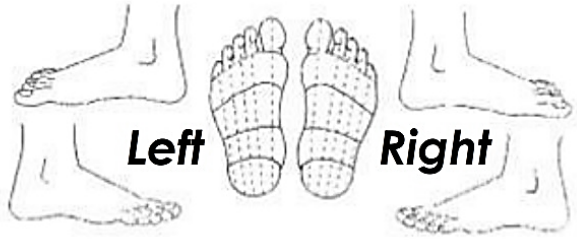
IF PATIENT IS A MINOR:

MOTHER NAME:	**DATE OF BIRTH:**
FATHERS NAME:	**DATE OF BIRTH:**

INSURANCE INFORMATION:

SUBSCRIBER NAME:	**PATIENT'S RELATIONSHIP:**
SUBSCRIBERS DATE OF BIRTH:	**SUBSCRIBERS SOCIAL SECUIRTY NUMBER:**
WHO IS YOUR PRIMARY DOCTOR?	
WHAT IS YOUR EMAIL ADDRESS?	

PLEASE MARK THE LOCATION OF YOUR PROBLEMS:



IS THIS PROBLEM WORK RELATED?		**IF YES, DATE OF INJURY:**		
PLEASE CIRCLE THE ASSOCIATED PAIN BELOW:				
SHOOTING PAIN **ACHING PAIN**	**THROBBING PAIN** **TENDERNESS**	**SHARP PAIN** **ITCHING**	**BURNING PAIN** **DULL PAIN**	**TINGLING PAIN** **NUMBNESS**

COASTAL FOOT CARE SERVICES, INC.
NEW PATIENT INFORMATION FORM

PLEASE CHECK IF YOU HAVE YOU HAD/BEEN TREATED FOR:

- ☐ LOW BACK PAIN
- ☐ CHILDHOOD FOOT PROBLEM
- ☐ BROKE FOOT BONE(S)
- ☐ HAMMERTOES
- ☐ LEG OR FOOT ULCERS
- ☐ ANKLE INJURY
- ☐ KNEE PAIN
- ☐ HIGH ARCH FEET
- ☐ BUNIONS
- ☐ INGROWN NAILS
- ☐ NEUROMA
- ☐ RASH
- ☐ ARCH PAIN
- ☐ HEEL PAIN
- ☐ FLAT FEET
- ☐ CORN/CALLOUSES
- ☐ WART
- ☐ ATHLETE'S FOOT

HAVE ANY OF YOUR FAMILY MEMBERS HAD ANY OF THESE CONDITIONS?

- ☐ DIABETES
- ☐ ARTHRITIS
- ☐ STROKE
- ☐ CANCER
- ☐ FOOT PROBLEMS
- ☐ HEART ATTACK
- ☐ HIGH BLOOD PRESSURE
- ☐ BIRTH DEFFECTS

ARE YOU CURRENTLY PREGNANT?
AFTER A CUT, DO YOU HEAL SLOWLY?
ARE YOU TAKING INSULIN?
WHAT PERCENTAGE OF A DAY ARE YOU ON YOUR FEET?
DO YOUR FEET HURT AT NIGHT?
DO YOU HAVE DIFFICULTY WALKING?
DO YOU GET LEG CRAMPS?
DO YOU HAVE ANY PAIN IN YOUR CALVES OR BOTTOM OF YOUR FEET WHEN WALKING?
IS YOUR PAIN RELIEVED BY REST?

PLEASE CHECK IF YOU HAVE OR HAD ALLERGIES TO:

- ☐ PENICILIN
- ☐ MORPHINE
- ☐ CODEINE
- ☐ DEMEROL
- ☐ NOVOCAINE
- ☐ ASPIRIN
- ☐ ADVIL, ALEVE, OR MOTRIN
- ☐ TYLENOL
- ☐ OTHER PAIN REMEDIES: _____
- ☐ LATEX
- ☐ ADHESIVE TAPE / BAND AID
- ☐ SULFA DRUGS
- ☐ SHRIMP
- ☐ IODINE OR METHIOLATE
- ☐ OTHER: _____

PLEASE LIST YOUR PAST SURGERIES OR MAJOR HOSPITILIZATIONS IF APPLICABLE:

_____

PLEASE LIST ANY MEDICAL CONDITIONS:

_____

COASTAL FOOT CARE SERVICES, INC.
NEW PATIENT INFORMATION FORM

PLEASE LIST YOUR PRESCRIBED MEDICATIONS AND VITAMINS:

MEDICATION NAME	STRENGTH	FREQUENCY TAKEN

MEDICAL HISTORY:

PLACE A CHECK MARK ON "YES" OR "NO" IF YOU HAVE HAD ANY OF THE FOLLOWING:

AIDS/HIV	☐ YES	☐ NO	ALLERGIES TO ANESTHETICS	☐ YES	☐ NO
ALLERGIES TO MEDICINE OR DRUGS	☐ YES	☐ NO	ANEMIA	☐ YES	☐ NO
ANGINA	☐ YES	☐ NO	ARTHRITIS	☐ YES	☐ NO
ARTIFICIAL HEART VALVES OR JOINTS	☐ YES	☐ NO	ASTHMA	☐ YES	☐ NO
BACK PROBLEMS	☐ YES	☐ NO	BLEEDING DISORDERRS	☐ YES	☐ NO
CANCER	☐ YES	☐ NO	CHEMICAL DEPENDENCY	☐ YES	☐ NO
CHEST PAIN	☐ YES	☐ NO	CHORNIC DIARRHEA	☐ YES	☐ NO
CIRCULATORY PROBLEMS	☐ YES	☐ NO	DIABETES	☐ YES	☐ NO
EAR PROBLEMS	☐ YES	☐ NO	EPILEPSY	☐ YES	☐ NO
FAINTING	☐ YES	☐ NO	FOOT OR LEG CRAMPS	☐ YES	☐ NO
GOUT	☐ YES	☐ NO	HEADACHES	☐ YES	☐ NO
HEART DISEASE	☐ YES	☐ NO	HEMOPHILIA	☐ YES	☐ NO
HEPATITIS OR JAUNDICE	☐ YES	☐ NO	HIGH BLOOD PRESSURE	☐ YES	☐ NO
KIDNEY PROBLEMS	☐ YES	☐ NO	LIVER DISEASE	☐ YES	☐ NO
LOW BLOOD PRESSURE	☐ YES	☐ NO	NEUROPATHY	☐ YES	☐ NO
PHLEBITIS	☐ YES	☐ NO	PSYCHIATRIC CARE	☐ YES	☐ NO
RADIATION TREATMENT	☐ YES	☐ NO	RASH	☐ YES	☐ NO
RESPIRATORY DISEASE	☐ YES	☐ NO	RHEUMATIC FEVER	☐ YES	☐ NO
SHORTNESS OF BREATH	☐ YES	☐ NO	SINUS PROBLEMS	☐ YES	☐ NO
SPECIAL DIET	☐ YES	☐ NO	STROKE	☐ YES	☐ NO
SWELLING IN ANKLES, FEET	☐ YES	☐ NO	SWOLLEN NECK GLANDS	☐ YES	☐ NO
TIRED FEET	☐ YES	☐ NO	TUBERCULOSIS	☐ YES	☐ NO
ULCERS	☐ YES	☐ NO	VARICOSE VEINS	☐ YES	☐ NO
VENEREAL DISEASE	☐ YES	☐ NO	WEIGH LOSS, UNEXPLAINED	☐ YES	☐ NO

TOBACCO & ALCOHOL	DO YOU USE TOBACCO?	☐ YES	☐ NO	
	CIGARETTES – PACKS/ DAY	# OF YEARS	☐ OR YEARS QUIT	
	DO YOU DRINK ALCOHOL?	☐ YES	☐ NO	IF YES, HOW MANY DRINKS PER WEEK?

Treatment consent: I hereby consent and give my permission to Coastal Foot Care Services, Inc. (Dr. Glodowski) to administer and perform such procedures, as the doctor deems necessary.

Release of Medical information: I hereby authorize Coastal Foot Care Services, Inc. (Dr. Glodowski) to furnish information to and from any referring Physician, Lab, pharmacy, or insurance company. I also authorize Dr. Glodowski to receive information from other physicians relating to patient care**.**

Patient Financial Policy:

I understand that insurance plans vary in the amount of coverage, and I am responsible for the payment of my account directly to Dr. Glodowski. I authorize the use of this form for all my insurance submissions, and the release of medical information to all my insurance companies.

There is a $35.00 charge for **no show appointments or same day cancellations**. When you do not show up for your appointment or re-schedule in less than 36 hours, it is impossible for us to fill that slow in such short notice.

There will be a $35.00 charge for **returned checks**.

X _____ X _____

Signature of patient, guardian, representative Date

X _____

Please print your name

Notice of privacy practices acknowledgement:
HIPAA REGULATIONS:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

My signature below indicates that I have been provided with a copy of the notice of privacy practices.

X _____ X _____

Signature of patient or representative | Date

X _____

Relationship to patient

Would you like to have a copy of HIPPA privacy?

☐ Yes | ☐ No