Faragalla Foot Care LLC

6120 53rd Ave (SR 70) East
Bradenton, FL 34203
Phone: 813-444-3022

4020 Sawyer Rd
Sarasota, FL 34233
Phone: 813-444-3022

Patient Information

Last Name:	First Name:	DOB: ___/____/_____	Sex: ○M ○F
Address:	Apt:	City/State:	Zip:
Home Phone:	Cell:	Work:	
Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___			
E-mail: _____.com			

Contacts

Emergency contact:	Relationship:	Phone:
Primary Care Physician:	Date Last seen:	Phone:
Who referred you?		
Pharmacy:	Phone:	

Payment

Who is responsible for payment?			
Insurance name:	Member ID:	Group#:	
Subscriber's name:	DOB:	Your Relationship to Subscriber:	
Do you have secondary insurance?	Insurance name:	Member ID:	

Medical History

Do you have history of the following?

Acid Reflux	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Open Sores	Y	N
Arthritis	Y	N	Heart Attack	Y	N	Pneumonia	Y	N
Asthma	Y	N	Heart Disease/Failure	Y	N	Polio	Y	N
Back Trouble	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Bladder Infections	Y	N	HIV+/AIDS	Y	N	Sickle Cell Disease	Y	N
Abnormal Bleeding	Y	N	High Blood Pressure	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	Kidney Disease	Y	N	Sleep Apnea	Y	N
Blood Transfusion	Y	N	Liver Disease	Y	N	Stomach Ulcers	Y	N
Bronchitis/Emphysema	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Cancer	Y	N	Migraine Headaches	Y	N	Thyroid Disease	Y	N
Diabetes	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N
Other Conditions:								

Medication	Dose	How often taken

Surgery Type	Date

Hospitalization Reason	Date

Allergies?	**Type:**

Social History

Marital Status: ○Single ○Married ○Partnered ○Separated ○Divorced ○Widowed	
Use of Alcohol: ○Never ○Occasionally ○Often ○History of Abuse	
Use of Tobacco: ○Never ○Occasionally ○Often ○History of Abuse	
Use Recreational Drug: ○Never ○Occasionally ○Often ○History of Abuse	
Occupation:	**On feet:** ○10% ○25% ○50% ○75% ○100%

Family History

○ Diabetes ○ Cancer ○Heart Disease ○ High Blood Pressure ○Stroke ○Coronary Artery Disease

○Thyroid Disease ○ Rheumatoid Arthritis ○Other: _____

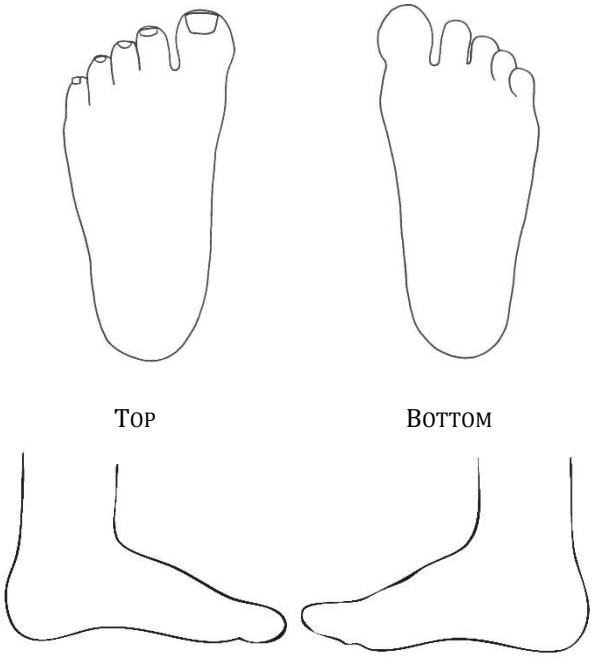
Relation: _____

Your Visit

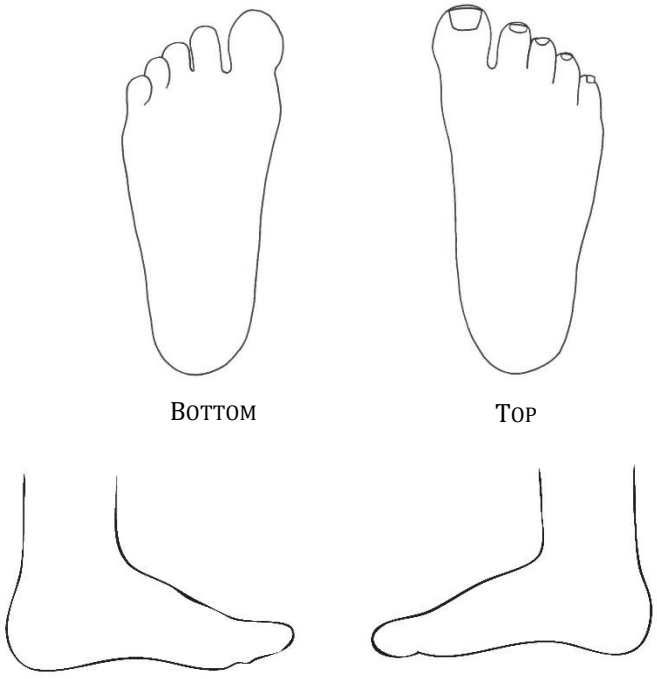
What brings you to our office today? _____

Where is the pain/problem located? Please mark on the pictures below.

Left Foot



Right foot



To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_____ _____

Signature Date

Consent to treat, HIPAA and Office Policy

I have been made aware of my condition by my health care provider and agree to have medical care and appropriate podiatric procedures performed at Faragalla Foot Care, LLC. The treatment will be in accordance with my diagnosis and in consultation with my physician or health care provider.

I accept to receive automated text and/or voice messages at the phone number(s) provided.

I have also been provided with a copy of Faragalla Foot Care, LLC HIPAA Privacy Notice and have been given ample opportunity to read and ask questions about said notice.

_____ _____

Patient Signature Date

I authorize the release of medical or other information necessary to process my insurance claims. I authorize payment of medical benefits to the providers at Faragalla Foot Care, LLC. I permit a copy of this authorization to be used in place of an original. I accept full responsibility for the full amount due for services provided for me.

I understand that all insurance forms that I have signed may be sent to my insurance company or employer on my behalf. Any payments that are received by me for services rendered by Faragalla Foot Care, LLC will be endorsed and presented immediately along with an explanation of benefits. I also understand that any insurance deductibles or co-insurance is my responsibility to pay to Faragalla Foot Care, LLC.

I also understand that I am responsible to present any information pertinent to the processing of any claims. If my insurance information changes, I must alert the office staff at Faragalla Foot Care, LLC immediately.

_____ _____

Patient Signature Date