Welcome to Our Practice

Paul A. Santangelo, DPM

Thank you for choosing our office! Please fill out the information on **both sides** to the best of your ability. Please print. All information will be confidential.

Patient name____
FIRST MIDDLE LAST

Birthdate______________ ☐ Male ☐ Female Home Phone #:____________________ Cell Phone #:__________________________

Address____ City________________________ State_________ Zip________

E-mail address____ Preferred contact method: ☐ Home ☐ Cell ☐ Work ☐ E-mail

Patient's or parent's employer____________________________________ City______________Work phone #:________________

Spouse or parent's name____ Phone #__________________________

How did you hear about our practice? ☐ Friend/Family: _____________________ ☐ Doctor referral:_____________________

☐ Insurance ☐ Internet/Google ☐ Facebook ☐ Other: ____________________________

Emergency contact___________________________________ Relationship____________________ Phone #____________________

Primary care physician____

Address____ City____________________ State_________ Zip________

Phone________________________ **Date last seen**_________________

History of Present Foot/Ankle Condition:

Chief complaint today ____

Location ____
(Where is the pain/problem?)

Severity ____
(How severe is the pain on a scale of 1-10 (10 being the most severe)

Duration____
(How long have you had this pain/problem, or when did it start?)

Timing ____
(Does this problem/pain occur at a specific time?)

Context____
(Where or what were you doing at the onset of this pain/problem?)

Authorization & Release

I authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X____ Date_____________________
Signature of patient (or parent if minor)

Patient Medical History:

Please review the following and indicate if you have or had any of the following
(check "no" or yes", leave blank if uncertain)

Diabetes	□ No □ Yes	Cancer	□ No □ Yes	Blood or Plasma Transfusions	□ No □ Yes	Bladder Infections	□ No □ Yes
Heart Disease	□ No □ Yes	Parkinson's Disease	□ No □ Yes	Bleeding Tendency	□ No □ Yes	Migraine Headaches	□ No □ Yes
High or Low Blood Pressure	□ No □ Yes	Kidney Disease	□ No □ Yes	Anemia	□ No □ Yes	Hives or Eczema	□ No □ Yes
Mitral Valve Prolapse	□ No □ Yes	Thyroid Disease	□ No □ Yes	Polio	□ No □ Yes	Back Trouble	□ No □ Yes
High Cholesterol	□ No □ Yes	Epilepsy	□ No □ Yes	Tuberculosis	□ No □ Yes	Ulcer	□ No □ Yes
Stroke	□ No □ Yes	Asthma	□ No □ Yes	Hepatitis	□ No □ Yes	Venereal Disease	□ No □ Yes
Pneumonia	□ No □ Yes	Arthritis	□ No □ Yes	AIDS or HIV+	□ No □ Yes		
		Glaucoma	□ No □ Yes				

Any Other Disease □ No □ Yes
(please list)____

____

Previous Hospitalizations/Surgeries/Serious Illnesses When Hospital, City, State

______________________ ____________ ______________________

______________________ ____________ ______________________

______________________ ____________ ______________________

Medications (include non-prescription):

________________ ________________ ________________

________________ ________________ ________________

________________ ________________ ________________

________________ ________________ ________________

________________ ________________ ________________

________________ ________________ ________________

Allergies:

____

Patient Social History:

Martial Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Use of alcohol: □ Never □ Rarely □ Moderate □ Daily

Use of tobacco: □ Never □ Yes, current packs/day______________ □ Previously, but quit:____________

Use of drugs: □ Never □ Yes, type/frequency:______________