Dr. Phillip D. Narcissi D.P.M
Dr. Johnny C. Rossi D.P.M

PATIENT INFORMATION

Shoe Size_______ Today's Date: _____________

Name:____ Date of Birth:____________

Address: ____________________________________City/State/Zip__________________

Phone:____________________Status(circle): Single --- Married--- Widowed---Divorced

Spouse Name:________________________ Parent Name (if minor)_______________

Patient Employed by:__________________________ Occupation:_________________

E-mail Address____

Name of Primary Physician:____

Referred to our office by:____

EMERGENCY CONTACT

Name:__________________________________ Relationship:____________________

Home Phone:_________________________ Cell Phone __________________________

MEDICAL INFORMATION

What foot/ankle problems bring you to our office? (Please designate RIGHT or LEFT)

____

When/How did this problem begin? ____

____

Has this been treated before? ___________ By Whom? __________________________

Current Height:______ Weight_____Your General Health is: Good___Fair___ Poor___

For Women Only: Are you Pregnant?___________ If so, How many months?_________

Please list any MEDICATIONS you are currently taking (include herbals) ___________

____

Please list all ALLERGIES/DRUG reactions (don't forget Adhesive tape, Aspirin, Novocain, Penicillin, Iodine) ____

____

Please list all SURGERIES/OPERATIONS you have had:___________________________

____

Do you have Diabetes/Borderline?_____Most Recent A1C_____Date of test:________

Do you have any CRAMPS/NUMBNESS/TINGLING in your feet or legs? ___________

If yes, when does this occur?____

Please indicate FAMILY history of the following:

Diabetes______ Heart Disease_______ Arthritis_______ Circulation Disorder______

Please check "**YES**" or "**NO**" to indicate if YOU have had any of the following problems:

YES	NO	NATURE OF PROBLEM	COMMENT/APPROX.DATE
		Recent Weight Loss/Gain	
		Trouble with Vision	
		Trouble with Hearing	
		Asthma/Allergies	
		Thyroid	
		Skin/Scarring Tendency	
		Anemia	
		Heart/Mitral Valve Prolapse	
		Circulation/Varicose Veins	
		High Blood Pressure/Stroke	
		Breathing Problems	
		Liver/Gallbladder/Stomach	
		Swelling of Feet/Ankles	
		Arthritis/Joint Pain	
		Kidney Disease/Stones	
		Gout	
		Bleeding Tendency	
		Broken Bones	
		Psychiatric	
		Epilepsy/Fainting/Neurological	
		Cancer	
		Hepatitis	
		Do you Smoke? How Much/Often?	
		Do you drink Alcohol? How Much/Often?	
		HIV Positive?	

Patient Agreement & Authorization

Please indicate you have read and agree to each of the following terms by initialing on the preceding blank.

______**Acknowledgment of Receipt of Notice of Privacy Practices:**
I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

______**Acknowledgement of Financial Responsibility:**
I acknowledge that regardless of my insurance benefits, if any, that I am responsible for fees and services rendered. In the event of nonpayment, I understand that I am responsible for collection, attorney and court costs.

______**Authorization of Treatment:**
I request and authorize Dr. Narcissi or Dr. Rossi and staff to administer treatment and to perform such general procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle condition.

______**Authorization of Release of Information:**
I authorize the release of my medical record information to the following:

Name:________________________________ Relationship to Patient:____________

Name:________________________________ Relationship to Patient:____________

______**I certify,** to the best of my knowledge, the information provided here is true and accurate.

____ ________________
Patient Name (please print) Date

____
Parent or Authorized Representative (if applicable)

____
Signature