Emerald Coast Podiatry and Wound Care Center

PATIENT INFORMATION FOR
COSIMO A RICCIARDI, D.P.M. & NEIL PATEL, D.P.M.

PATIENT NAME: _____ SEX: F M

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

HOME PHONE: _____ CELL#: _____ WORK #: _____

MARITAL STATUS: SINGLE: ____ MARRIED: ____ OTHER: ____

PRIMARY PHYSICIAN: _____ REFERRED BY: _____

EMPLOYER: _____

EMAIL: _____

PLEASE LIST ANY FAMILY MEMBERS OR OTHER PERSON, IF ANY, WHOM WE MAY INFORM OR DISCUSS YOUR GENERAL MEDICAL CONDITION AND DIAGNOSIS WITH, INCLUDING TREATMENT, PAYMENT, HEALTH CARE, OPERATIONS AND PROCEDURES.

NAME: _____ PHONE #: _____

NAME: _____ PHONE #: _____

***Please indicate if a confidential message can be left on your answering machine or voicemail.
YES _____ NO _____

GUARANTOR INFORMATION:

(Person Responsible for the Bill. If this is not the patient, fill this section out entirely)

NAME: _____ SEX: F M

STREET ADDRESS: _____

CITY : _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

HOME PHONE: _____ CELL #: _____ WORK #: _____

EMPLOYER: _____

Emerald Coast Podiatry and Wound Care Center

MEDICAL HISTORY

Patient Name: _____

Family Physician: _____ Date last seen: _____

Pharmacy: _____

Social History:
Do you smoke? Yes __ No __. If yes, how much do you smoke? _____ How Long (years) ____
Have you ever smoked? Yes __ No __. If yes, when did you quit Years _____ Months____ Day ___
Do you drink Alcoholic products? Yes __ No __. If yes, socially ___ moderately ___ heavily ___

List **ALL MEDICATIONS** which you now use: _____
_____
_____

List **ALL ALLERGIES OR PROBLEMS WITH DRUGS, MEDICATION, TAPE, DYES LOCAL OR GENERAL ANESTHESIA:** _____
_____
_____

Medical Equipment: Cane ___ Walker ___ Wheelchair ___ Oxygen ___ Special Shoes ___
Glasses ___ Contact Lenses ___ Arch Support ___ Lifts in shoes ___ AFO Braces ___

Your Age: ____ Weight ___ Height ___ Shoe size and width _____

Are you required to take Antibiotics prior to Surgery or Dental Procedure? Yes ___ No ___
If yes, because of Mitral Valve prolapse ____, Prosthetic or Implant Surgery _____,
Heart Valve, Hip or Knee Surgery _____, Other _____.

Are you Pregnant: Yes ___ No ___ if yes how many months: _____

Is there anything this form **DID NOT COVER** that your Doctor needs to know about you?
Yes ___ No ___, If yes, _____
_____

I hereby give permission to Dr.Cosimo Ricciardi/Dr.Neil Patel to examine and treat the feet, ankle and lower extremity of the below named patient.

_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**

EMERALD COAST PODIATRY AND WOUND CARE CENTER

MEDICAL INFORMATION

PATIENT NAME: _____ **DATE:** _____

Do you have or have you ever been treated by a physician for any of these following illnesses?

YES	NO	ILLNESS
____	____	ACID REFLUX
____	____	ANEMIA
____	____	ARTHRITIS
____	____	ASTHMA
____	____	BLEEDING TENDENCY
____	____	BLOOD CLOTS (PHLEBITIS)
____	____	CIRCULATORY PROBLEMS
____	____	DIABETES
____	____	EMPHYSEMA
____	____	EPILEPSY/SEIZURES
____	____	GOUT
____	____	HEART ATTACK
____	____	HEPATITIS
____	____	HIGH BLOOD PRESSURE /HTN
____	____	JOINT REPLACEMENT
____	____	KIDNEY DISEASE
____	____	LIVER DISEASE
____	____	MITRAL VALVE PROLAPSE
____	____	PSYCHIATRIC CARE
____	____	RHEUMATIC FEVER
____	____	SCARRING TENDENCY
____	____	SEXUAL TRANSMITTED DISEASE
____	____	STOMACH ULCERS / GERD
____	____	STROKE / TIA
____	____	THYROID
____	____	VARICOSE VEINS

OTHER ILLNESSES NOT LISTED ABOVE:

_____
_____
_____

FAMILY HISTORY

	LIVING	PASSED	MEDICAL CONDITIONS
MOTHER:			_____
FATHER:			_____
BROTHER(S)			_____
SISTER(S):			_____

LIST ALL OPERATIONS (INCLUDING ANY FOOT SURGERIES) WITH IN THE YEAR:

PROCEDURE / SURGERY	DATE / YEAR
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

EMERALD COAST PODIATRY AND WOUND CARE CENTER

COSIMO A. RICCIARDI, D.P.M. / NEIL PATEL, D.P.M.

REQUEST FOR MEDICAL RECORDS

TO: _____
NAME OF HEALTHCARE PROVIDER/PHYSICIAN/FACILITY

RE: _____
PATIENTS NAME

DOB: _____ **SS#:** _____

I authorize and request the disclosure that the designated record custodian of all covered entities under HIPAA indentified above disclose full and complete protected medical information including the following:

ALL MEDICAL RECORDS, INCLUDING BUT NOT LIMITED TO: OFFICE, NOTES, FACE SHEETS, HISTORY AND PHYSICAL, CONSULTATION NOTES, INPATIENT,OUTPATIENT AND EMERGENCY ROOM TREATMENT, ALL CLINICAL CHARTS, PROGRESS NOTES,NURSE'S NOTES, TREATMENT PLANS, ADMISSION RECORDS,DISCHARGE SUMMARIES,REQUESTS FOR AND REPORTS OF CONSULTATION,DOCUMENTS,CORRESPONDENCE, TEST RESULTS.

OR: _____

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome(AIDS), or human immunodeficiency virus(HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.
This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.
You are authorized to release the above records to the following representatives of defendants in the above-entitled matter:

EMERALD COAST PODIATRY AND WOUND CARE CENTER
Cosimo A. Ricciardi, D.P.M./Neil Patel, D.P.M. and office staff

I UNDERSTAND THE FOLLOWING:

a. I have a right to revoke this authorization in writing at any time.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or authorization shall be in force and effect until two years from date of execution at which time it expires.

_____ _____
Signature of Patient or legally Authorized Representative **Date**

_____ _____
Witness Signature **Date**

FORT *WALTON BEACH OFFICE*
341 A RACETRACK RD NW
FT. WALTON BEACH, FL 32547
PHONE: 850 862-4119 FAX: 850-862-5470

CRESTVIEW OFFICE
120 E. REDSTONE AVE, SUITE A
CRESTVIEW, FL 32539
PHONE: 850-682-6522 FAX: 850-423-5673

EMERALD COAST PODIATRY & WOUND CARE CENTER
COSIMO A. RICCIARDI,D.P.M.
NEIL PATEL, D.P.M.

PATIENT'S NAME _____

TO AVOID A $25 CANCELLATION FEE, A 24 HOUR NOTICE IS REQUIRED.

I UNDERSTAND THAT THE FEE MUST BE PAID PRIOR TO RESCHEDULING.

THIS FEE IS NOT COVERED BY INSURANCE.

SIGNATURE: _____

DATE: _____

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at Emerald Coast Podiatry, it may be medically necessary to obtain a blood, tissue, or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no linger needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state, and federal requirements.

It may also be the case that a biological specimen (such as blood, wound fluid, etc.) from you may be deposited on medical instruments, or other objects. These objects may then be transferred to a third party for cleaning and disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to transfer of any and all biological specimens collected by or deposited with Emerald Coast Podiatry to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

_____

Signature of Patient

_____

Printed Name of Patient

_____

Date