3301 SW 34TH CIRCLE STE 102
Ocala, Fl 34474
352-861-0444 office
352-861-0464 fax

Suncoast Podiatry Associates, Inc.
Stephen R Miller DPM
Timothy J Whyatt DPM

NEW PATIENT INTAKE FORM

Name:____Gender _____M _____F

Date of Birth:_________________________Age__________________Social Security #:_______________________

Address: ________________________________City:____________________________State:_____Zip_________

Home Phone #:___________________Work Phone#:__________________Cell Phone:________________________

Marital Status: _____Single _____Married _____Divorced _____Widowed _____Partner _____Legally Separated

Emergency Contact: ______________________Phone:_____________________Cell Phone:__________________

E-Mail Address:_______________________________ Primary Spoken Language ____________________________

Employment Status ____Full-Time _____Part-Time ____Not Employed

Student Status ____Full-Time _____Part-Time ____Not a Student

Race:
American Indian or Alaska Native ______ Native Hawaiian or other Pacific Islander ______

Black or African American ________ Asian ______ White ______

The items with an asterisk are required:

Ethnicity:
Hispanic or Latino ________ Not Hispanic or Latino________

Primary Care Physician:________________________________*Referred by:_________________________________

Cardiologist:____Endocrinologist:_______________________________

Nephrologist:____Rheumatologist: ______________________________

*****Please describe your foot/ankle problem (include date of injury if applicable) *****

How long has the problem been present? ____

Have you had any treatment or taken anything for it? ____

Have you seen someone for this already? _No _Yes Whom?____________________________________

Have you had any prior foot/ankle problems? If yes, please describe: ___No Yes___________________________

3301 SW 34TH CIRCLE STE 102
Ocala, Fl 34474
352-861-0444 office
352-861-0464 fax

Suncoast Podiatry Associates, Inc.
Stephen R Miller DPM
Timothy J Whyatt DPM

WELCOME TO OUR OFFICE!

ALLERGIES

Please check all allergies:

_____Medications:____

_____Foods:____

_____Tapes or Topical Skin Sensitivity______Other:________________________________

What types of reactions have you experienced?
____

____

MEDICATIONS

Please list all medications and the dosages:

1.______________________ 6.______________________

2.______________________ 7.______________________

3.______________________ 8.______________________

4.______________________ 9.______________________

5.______________________ 10.______________________

Personal Medical History:

****Check those that apply to you now or have applied to you in the past****

	Frequent Headache/Migraines		Anemia/Blood Disorders
	Liver Disorder		Pneumonia
	Kidney Disease		Drug/Alcohol Abuse
	Dialysis M W F or T TH SA		Epilepsy or Seizures
	Diabetes Average Blood Sugar _______		Prolonged Bleeding Time
	Asthma		Stomach/Ulcer Disorder
	Emphysema		Thyroid/Parathyroid Disease
	Heart Trouble		High Blood Pressure
	Stroke		Arthritis
	Chest Pain on Mild Exertion		Psychiatric Treatment
	Gout		Emotional Problems/Tension
	BLOOD CLOTS		Asthma/Hay Fever/Shortness of Breath
	Tumor/Abnormal Growth/Cancer		Sexually Transmitted Disease
	Ear, Nose, Throat Disorder		Prostate Disorder
	Hepatitis/HIV		Other

3301 SW 34TH CIRCLE STE 102
Ocala, Fl 34474
352-861-0444 office
352-861-0464 fax

Suncoast Podiatry Associates, Inc.
Stephen R Miller DPM
Timothy J Whyatt DPM

WELCOME TO OUR OFFICE!

SURGICAL HISTORY

Surgical Procedures/Serious Injuries/Illnesses	Year	Physician	Hospital

Has any **family member** had any of the following (please indicate relationship)

Cancer: ____ Diabetes: ______________________________________

Heart Trouble: ____ High Blood Pressure: ____________________________

Kidney Disease: _______________________________________ Mental or Emotional Disease: ______________________

Stroke: ____ Tuberculosis: ___________________________________

Arthritis: ____ Emphysema: ____________________________________

Blood clots: ____ Other:

PATIENT INFORMATION

Do you smoke nicotine products currently ______Yes, _______No

Do you currently smoke marijuana or use other THC / CBD products ________yes, _______No

Number of caffeine drinks per day? ______ Amount of alcohol consumed per week ______

For women only: Are you pregnant? ______ How many months? ______

Please complete the following:

Height: ________ **Weight:** ________ **Shoe size:** ________ Occupation: ____

Is there any other information you would like us to be aware of: ______No ___Yes

Please describe: ____

Do you currently have a Care Plan? (please circle all that apply): None DNR Living Will Durable Power of Attorney

Designated a surrogate decision maker

Surrogate Name ____________________________________

3301 SW 34TH CIRCLE STE 102
Ocala, Fl 34474
352-861-0444 office
352-861-0464 fax

Suncoast Podiatry Associates, Inc.
Stephen R Miller DPM
Timothy J Whyatt DPM

You are almost done!!!

****Please circle all that *currently* apply to you****

Muscular/ Skeletal: back pain joint pain joint redness joint swelling leg cramps morning stiffness
muscle tenderness neck pain stiffness weakness of muscles difficulty with walking

Neurological: burning in feet tingling in feet or toes numbness tremors

Genitourinary: blood in urine hesitancy incontinence increased urgency
Decreased frequency excessive urination kidney disease kidney stones

Psychiatric: addictions attempted suicide depression memory loss panic attacks

Respiratory: Chest Pain Wheezing COPD Coughing Emphysema Shortness of breath

Gastrointestinal: abdominal pain heartburn blood in stool vomiting ulcers constipation
Diarrhea trouble swallowing decreased appetite increased appetite

Hematologic: lower leg Ulcers Sickle cell disease anemia blood thinners Clotting disorders

Integumentary Athletes foot Nail abnormalities keloids itchiness dry, scaly skin

Cardiovascular: Leg Pain When walking fainting fever chest pain/ pressure leg swelling
cold hands/feet Valve problems vascular disease

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and or medical staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of information): I authorize the release of any medical information necessary to process this claim. (HIPPA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

I hereby authorize direct payment of surgical and medical benefits on my behalf to the provider of these services that I would otherwise be payable to me if I did not make this assignment. I understand that I am personally responsible to the physician for charges not covered by my insurance agreement. I also understand that if my account becomes delinquent, I will be responsible for any costs of collection of my account, including collection fees and attorney costs. A $5.00 per month re-invoicing fee may apply to all accounts 60 days past due. I permit a copy of this assignment to be used in place of the original for purposes of billing.

I acknowledge that if my insurance requires a referral, whether it be paper or electronic, that I am responsible for getting an up to date and valid referral. I understand that failure to do so may result in my charges being my responsibility and that payment will be due from me directly.

The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital generated. Also, I herby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition, to use x-ray examination, or photographs as necessary.

I give Suncoast Podiatry Associates permission to obtain and release medical information to insurance companies and referring physicians. I have read the following and understand and agree

____
DATE

____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

**If not patient, relationship to patient:
___Parent ___Power of attorney ___Legal Guardian ____Other: _______________