



NORTH SHORE
FOOT & ANKLE INSTITUTE
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Board Certified
 Diplomat, American Board of Podiatric Surgery
 Fellow, American College of Foot & Ankle Surgeons

WELCOME TO OUR OFFICE

TODAY'S DATE / /

Patient Name (First) (Initial) (Last) _____

Address City State N.Y _____

Phone:() Cell Phone:() Date Birth / / Age _____

Sex: Male Female Email address: Social Security # _____

Height Weight Marital Status: Single/Married/Divorced/Widow/Student _____

Patient's Employer: Business Phone _____

Emergency Contact: Name: Telephone number Relationship _____

Referred By (How did you hear about us?) _____

Primary Care Physician: Address _____

Are you being seen as a result of an accident? Yes No Date of accident / / claim # _____

INSURANCE INFORMATION:

Name of insured Relationship to patient Insured DOB _____

SS# Insurance Company ID# _____

Group number Insurance/ claims address _____

Telephone number insurance company _____

Secondary insurance company:

Name of insured Relationship to patient Insured DOB _____

SS# Insurance Company ID# _____

Group Number Insurance co. address _____

OVER



PATIENT HISTORY: 1. What **foot problems** are you currently having? _____

When did your foot problem begin? _____

2. Are you presently under the care of a physician yes no ?
If yes for what reason _____

3. Are you currently taking **any** medications? If yes please list _____

Do you have any allergies? (please list) _____

Medical history: please check those that apply

<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma	<input type="checkbox"/> Phlebitis/ DVT
<input type="checkbox"/> Circulation problem	<input type="checkbox"/> Eye/Ear problem	<input type="checkbox"/> Kidney/Liver Problem
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Bleeding/clotting problems	<input type="checkbox"/> Depression

List any others _____

Please list any surgeries and approximate dates _____

If female are you or could you be pregnant? Yes no
 Do you smoke? Yes no Do you drink alcohol? Yes No
 Have you had any joint replacement surgery? Yes no
 Do you have a pacemaker? Yes no
 Hospitalized in past five years? Yes no
 If yes, why _____

(ANY QUESTION NOT ANSWERED WILL BE TAKEN AS A NEGATIVE/ NO)

I hereby authorize payment of Medicare or other insurance benefits be made to my physician or supplier for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or other insurance carrier any and all information needed to determine these benefits or the benefits payable for related services. I understand and I agree that I am ultimately responsible (regardless of insurance status) for the balance on my account for any professional services rendered. I have read all the information on both sides of this form and answered all questions to the best of my knowledge. I will notify this office of any changes in my health status or changes in the information provided.

I have read and received (if I chose) the HIPAA privacy agreement:
I have the following requests:

SIGNATURE _____ DATE _____

PARENTS SIGNATURE (IF MINOR) _____ DATE _____