LEGAL NOTICE/DISCLAIMER
The information contained in this document does not establish a standard of care, nor does it constitute legal advice. The information is for general informational purposes only and is written from a risk management perspective to aid in reducing professional liability exposure. Please review this document for applicability to your specific practice. You are encouraged to consult with your personal attorney for legal advice, as specific legal requirements may vary from state to state.

Stephen Petrofsky, DPM, PA
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Port Charlotte, FL 33952
(941) 625-3330

Revised April 2019
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 understood the Notice.

_________________________________________  __________________________
Patient Name (please print)                  Date

_________________________________________
Parent or Authorized Representative (if applicable)

_________________________________________
Signature

Below please list any and all persons who are authorized to receive your personal health information. No information will be given to any person not listed, including your spouse.
1. _______________________________________
2. _______________________________________
3. _______________________________________
4. _______________________________________
PATIENT NAME: ______________________
DATE OF BIRTH: ____/____/_____ 

PATIENT INFORMATION FORM
(Please Print)

DATE: ____/____/____

PATIENT NAME: ______________________
LAST FIRST MI

DATE OF BIRTH: ____/____/____
AGE: ___ SEX: M F

HOME ADDRESS: ______________________
CITY/STATE: ______________________
ZIP: ____________

MAY WE LEAVE A MESSAGE?
YES NO

HOME PHONE #: (____) _____ - _____

WORK PHONE #: (____) _____ - _____

CELL PHONE #: (____) _____ - _____

E-MAIL: ______________________

PRIMARY LANGUAGE: ______________________

RACE: ______________________
ETHNICITY: ______________________

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: ______________________
RELATIONSHIP: ______________________
PHONE #: (____) _____ - _____

EMERGENCY CONTACT: ______________________
RELATIONSHIP: ______________________
PHONE #: (____) _____ - _____

PRIMARY CARE DOCTOR: ______________________
PHONE: ______________________

PHARMACY: ______________________
LOCATION: ______________________
PHONE #: (____) _____ - _____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
YES NAME(S) ______________________
NO

WHO IS RESPONSIBLE FOR PAYMENT?
RELATIONSHIP TO PATIENT: __________

ADDRESS: ________________
CITY/STATE: ________________
ZIP: ____________
PHONE #: (____) _____ - _____

HOW DID YOU FIND US?
(choose one)
GOOGLE/INTERNET
FRIEND/FAMILY
INSURANCE
FACEBOOK
DOCTOR REFERRAL (who?)

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: ______________________

ADDRESS: ________________
CITY/STATE: ________________
ZIP: ____________
PHONE #: (____) _____ - _____

INSURED NAME: ______________________
DATE OF BIRTH: ______

EMPLOYER: ______________________

CONTRACT #: ___________
GROUP #: ___________

SECONDARY INSURANCE COMPANY NAME: ______________________

ADDRESS: ________________
CITY/STATE: ________________
ZIP: ____________
PHONE #: (____) _____ - _____

INSURED NAME: ______________________
DATE OF BIRTH: ______

EMPLOYER: ______________________

CONTRACT #: ___________
GROUP #: ___________

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**PATIENT NAME:** ________________________________
**DATE OF BIRTH:** ____/____/____

**PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):**

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>How Often Do You Take?</th>
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**PLEASE LIST ALL PRIOR SURGERIES:**

<table>
<thead>
<tr>
<th>Type of Surgery</th>
<th>Date</th>
<th>Type of Surgery</th>
<th>Date</th>
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<tbody>
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</table>

**PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):**

<table>
<thead>
<tr>
<th>Reason for Hospitalization</th>
<th>Date</th>
<th>Reason for Hospitalization</th>
<th>Date</th>
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</tbody>
</table>

**SOCIAL HISTORY**

**Marital Status:**   Single   Married   Partnered   Separated   Divorced   Widowed

**Use of Alcohol:**   Never   No Longer Use   History of Alcohol Abuse
    Current Use - Type ________________   Rare   Occasional   Moderate   Daily

**Use of Tobacco:**   Never   Quit – How Long Ago? _______   Smoke ___ packs/day for ___ years

**Use of Recreational Drugs:**   Never   Quit – How Long Ago? _______ Type ________________
    Current Use - Type ________________   Rare   Occasional   Moderate   Daily

**Employer:** ___________________________  **Occupation:** ___________________________

**How Much Are You On Your Feet At Work?**   10%   25%   50%   75%   100%

**Do Others Depend Upon You For Their Care?**   Children–Age(s) _______   Pet(s)–What Kind? _______
    Elderly or Disabled Family Member   Other __________________________________________

**Exercise:**   Never   Rare   Occasional   Weekly   Several Times A Week   Daily

**Types of Exercise:** _________________________________________________________________

**FAMILY HISTORY**

**Do You Have A Family History Of:**   Diabetes: Type 1 or Type 2   Cancer   Heart Disease
    High Blood Pressure   Stroke   Coronary Artery Disease   Thyroid Disease
    Rheumatoid Arthritis
PATIENT NAME: ____________________________
DATE OF BIRTH: ____/____/____

\ Other ________________________________

**YOUR MEDICAL HISTORY**

**ALLERGIES:**
- \ Other ________________
  - \ Tape
  - \ Latex
  - \ Shellfish
  - \ Iodine
  - \ Other

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acid Reflux</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Anemia</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Asthma</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Back Trouble</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Bladder Infections</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Abnormal Bleeding</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Blood Clots</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Bronchitis/Empysema</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Cancer</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Diabetes: Type 1 or Type 2 (circle)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Other Conditions:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CURRENT PROBLEM**

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? ________________________________

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

![Left Foot](image1)

![Right Foot](image2)

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# Patient Information Form

**Patient Name:** ____________________________

**Date of Birth:** ___/___/____

<table>
<thead>
<tr>
<th>Inside of Foot</th>
<th>Outside of Foot</th>
<th>Outside of Foot</th>
<th>Inside of Foot</th>
</tr>
</thead>
</table>

**How Long Ago Did This Problem First Start?** _____ Days / Weeks / Months / Years

**Did Your Pain or Problem:**
- [ ] Begin all of a sudden
- [ ] Gradually develop over time

**How Would You Describe Your Pain?**
- [ ] No pain
- [ ] Sharp
- [ ] Dull
- [ ] Aching
- [ ] Burning
- [ ] Radiating
- [ ] Itching
- [ ] Stabbing
- [ ] Other ____________________________

**How Would You Rate Your Pain on a Scale from 0 to 10? (Please Circle)**

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

**Since the Time Your Pain or Problem Began, Has It:**
- [ ] Stayed the same
- [ ] Become worse
- [ ] Improved

**What Makes Your Pain or Problem Feel Worse?**
- [ ] Walking
- [ ] Standing
- [ ] Daily activities
- [ ] Resting
- [ ] Dress shoes
- [ ] High heels
- [ ] Flat shoes
- [ ] Any closed toe shoe
- [ ] Running
- [ ] Other ____________________________

**What Makes Your Pain or Problem Feel Better?** ____________________________

**What Treatments Have You Had for This Problem?** ____________________________

**How Has This Problem Affected Your Lifestyle or Ability to Work?** ____________________________

**Was This Problem Caused by an Injury?**
- [ ] Yes (Describe) ____________________________
- [ ] No

If yes, was it a work-related injury?
- [ ] Yes
- [ ] No

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**To the Best of My Knowledge, I Have Answered the Questions on This Form Accurately. I Understand That Providing Incorrect Information Can Be Dangerous to My Health. I Understand That It Is My Responsibility to Inform the Doctor and Office Staff of Any Changes in My Medical Status.**

**Print Name of Patient, Parent or Guardian** ____________________________

**Signature of Doctor** ____________________________

**If Other Than Patient, Relationship to Patient** ____________________________

**Date** ____________________________

**Signature** ____________________________

**Date** ____________________________

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