

West Coast Podiatry Center

1611 53rd Ave W., Bradenton, FL 34207 (941-753-9599)
1961 Floyd Street, Suite D, Sarasota, FL 34239 (941-366-2627)

Dr. Stephen D. Lasday Dr. Robert M. Goecker Dr. Alissa Zdancewicz Dr. Eric Vonherbulis

Patient Information

NAME: First: _____ MI: _____ Last: _____ DOB: _____ Age ()

[Sex: _____ M _____ F] [Race: _____ White _____ African Am _____ Hispanic _____ Asian _____ American Indian]

Social Security No: _____ [Marital Status: (circle) Single Married Divorced Widow]

Local Address _____ Apt# _____ City _____ Zip Code _____

**IS THIS A NURSING HOME OR ASSISTED LIVING FACILITY? _____ YES _____ NO

Ph No: _____ Cell : _____ Work Name: _____ Ph# _____

Emergency Contact _____ Relationship to Patient: _____ Ph No: _____

PERMANENT RESIDENT OF FLORIDA? Yes No E-Mail _____

Northern Address _____ City _____ ST _____ Zip Code _____

Ph No () _____

*****IF YOUR INSURANCE IS THROUGH ANOTHER PERSON, PLEASE FILL IN BELOW**

Relationship to patient: Spouse _____ Parent _____ Legal Guardian _____ Other _____

NAME: First: _____ MI: _____ Last: _____ DOB: _____

Address _____ City _____ ST _____ Zip Code _____

Ph No () _____ Work Ph No: () _____ Employer: _____

Guarantor Social Security No: _____

I authorize the physicians at West Coast Podiatry to submit insurance claims on my behalf. I authorize and assign benefits, payable by my primary and secondary insurance companies for my medical claims, to West Coast Podiatry Center, Inc. ***I agree that I am responsible for my deductible, co-pay and non-covered charges the day of the service. I will also assume full responsibility for all incurred charges my insurance company allows but does not pay. (All accounts must be kept current within 30 days of receiving a bill unless other arrangements have been made.)***

I realize that I am here for medical advice and possible treatment. I give permission to my treating doctor at West Coast Podiatry to perform those procedures that we have mutually agreed upon and to release my personal and/or medical information to other professional providers so that I may receive medical services from them. I understand that no guarantees or assurances have been made as to the results of any procedures or treatments.

SIGNATURE _____ Date _____

MEDICAL HISTORY

Name: _____ Height: _____ Weight: _____ Shoe Size: _____

Family Doctor: _____ Ph No _____ Date Last Seen _____

Diabetic Doctor: _____ Date Last Seen _____ Heart Doctor: _____

Pharmacy Name: _____ Ph No _____

Describe the condition that brought you to our office, including the location and duration of the problem:

IS THE ABOVE PROBLEM RELATED TO AN AUTO ACCIDENT OR WORK INJURY? ___ YES ___ NO

Are you seeing OR have you seen any doctor in the last year for an INJURY RELATED TO A CAR ACCIDENT, WORK RELATED INJURY OR ANY OTHER INJURY? ___ YES ___ NO

DO YOU HAVE HOME HEALTH OR HOSPICE COMING TO YOUR HOME? YES NO

1. LIST ANY SURGERIES:

2. LIST ALL MEDICATIONS: (or bring a list)

3. ALLERGIES: _____

SOCIAL HISTORY

SMOKING? ___ NEVER ___ FORMER (YR QUIT: _____) ___ OCCASIONAL ___ DAILY(#PACKS _____)

ALCOHOL? ___ NO ___ YES (HOW MANY DRINKS PER DAY _____)

RECREATIONAL DRUGS USE? ___ NO ___ YES

EXERCISE? ___ NONE ___ OCCASIONALLY ___ DAILY (What type: _____)

FAMILY HISTORY:

MOTHER: ALIVE? YES NO IF NO, CAUSE OF DEATH: _____

FATHER: ALIVE? YES NO IF NO, CAUSE OF DEATH: _____

DO ANY BLOOD RELATIVES SUFFER FROM?

___ Diabetes ___ Heart Disease ___ Cancer ___ Bleeding Tendencies ___ Other _____

Which Relative _____

Additional Comments: _____

OFFICE USE ONLY:

VITALS BP _____ PULSE _____ RESPIRATIONS _____

Name _____

Date: _____

Please check all that apply.

___ Weight Loss ___ Weight Gain

___ Fever

___ Fatigue

___ Headache(s)

___ Dizziness

___ Head Injury-Date: _____ Cause: _____

___ Cataracts

___ Glaucoma

___ Eyeglass Use

___ Asthma

___ COPD

___ Bronchitis

___ Shortness of breath

___ Hypertension (high blood pressure)

___ Varicose Veins

___ Leg Swelling

___ Leg pain when walking

___ Cold Feet

___ High Cholesterol

___ Irregular heart beat

___ Heart attack-Approximate Date _____

___ Stroke- Approximate Date _____

___ Hernia

___ Hepatitis Type: ___ A ___ B ___ C

___ Heartburn

___ GERD

___ G.I Bleeds

___ IBS (Irritable Bowel Syndrome)

___ Cirrhosis

Name: _____

___ Arthritis (please specify type) _____

___ Back Problem (please specify) _____

___ Spinal Stenosis

___ Fibromyalgia

___ Muscle Weakness

___ Drop Foot

___ Gout-Last Episode _____ Last Uric Acid Screening _____

___ Osteoporosis

___ Depression

___ Anxiety

___ Memory Loss

___ Psychiatric Disorders (please specify) _____

___ Thick Toe Nails

___ Foot Ulcers

___ Rash

___ Other skin conditions (please specify) _____

___ Burning in Feet

___ Numbness in Feet

___ Tingling in Feet

___ Sciatica

___ Other neuropathic disorders (please specify) _____

___ Thyroid Disease

___ Diabetes Controlled by ___diet ___pills ___insulin

___ Anemia

___ Blood Clots-Where: _____ Date: _____

___ Anticoagulants (blood thinners)

___ Cancer- Date: _____ Type: _____

___ HIV

West Coast Podiatry Center

Medical and Surgical Management of the Lower Extremity

Stephen D. Lasday, D.P.M., FACFAS

Robert M. Goecker, D.P.M., FACFAS

Alissa B. Zdancewicz, D.P.M., FACFAS

Eric VonHerbulis, MS, DPM, AACFAS

I _____ hereby authorize West Coast Podiatry to use and disclose my Protected Health Information (PHI) in the manner described below. I understand that my PHI may be redisclosed by the person or entity receiving my PHI from this office and then may no longer be protected by federal privacy regulations. I voluntarily sign this authorization and I understand that my health care will not be affected if I do not sign this form.

Category of PHI: All Medical Records Test Results X-rays

Please limit disclosure to: _____

Recipients: All Primary Care Physicians Specialists Home Health
 Physical Therapy Offices

Please limit disclosure to: _____

You may also disclose my PHI to the following family members:

1. _____
2. _____
3. _____

I also request that the employees of West Coast Podiatry use my PHI to:

1. Remind me of future appointments
2. Report all future testing results. (To enclosed but not limited to MRI and CT results, Culture and Blood test results, X-ray reports and any communication from another treating provider.
3. To discuss my account balances and communicate the need for any further information that will help process my insurance claims.

I understand by checking the above boxes and signing this form that I give permission to use my PHI for the purposes of diagnosing, treatment and referrals. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying this office in writing. I understand that revocation or modification will have no bearing on my PHI sent before that time.

Patient signature

Date

Date of Birth _____

www.westcoastpodiatry.com