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 Dr. Dustin Stroud

Patient Information

NAME: **First: _____MI: _____ Last: _____ DOB: _____Age ( )**

[*Sex*: ____ M _____ F_____ Other] [*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 ___OCCASIONALY ___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_____