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*)
5880 Rand Blvd, #209, Sarasota, FL 34238 (941-366-2627)

Dr. Stephen D. Lasday Dr. Alissa Zdancewicz Dr. Eric Vonherbulis Dr. Dustin Stroud Dr. Megan Saltzman

Please Print
NAME: First: _____ MI: _____ Last: _____ DOB: _____

[*Sex*: ____ M _____ F_____ Other] [*Race*: ____White ____African Am ____ Hispanic ____Asian ____American Indian]

[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: _____

E-Mail _____ PERMANENT RESIDENT OF FLORIDA? Yes No
If no please give us your northern address.

Northern Address _____City _____ST _____Zip Code_____

Ph No ( ) _____ **Snowbirds?** From _____to _____

*****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: _____

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

Do you live in an *Assisted Living Facility or a Skilled Nursing Home*? Yes No

Family Doctor: _____ Ph No _____ Date Last Seen _____

Diabetic Doctor: _____ Ph No _____ Date Last Seen _____
Date Last Blood test: _____ A1C: _____

Heart Doctor: _____ Ph No _____ Date Last Seen _____

Vascular Doctor _____ Ph No _____ Date Last Seen _____

Pharmacy Name: _____ **Ph 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, PRIMARILY _____ BEER _____ WINE_____ HARD LIQUOR (HOW MANY DRINKS? _____PER DAY_____ PER WEEK)

RECREATIONAL DRUGS? ____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? Which Relative _____
____Diabetes ____Heart Disease ____Cancer ____Bleeding Tendencies ____Other _____

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, Inc.
1611 53rd Ave W., Bradenton, FL 34207
1961 Floyd Street, Suite D, Sarasota, FL 34239

I _____ Date of Birth _____ 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. This form will remain in effect until I sign a new one or write a letter rescinding this one.

Permission to release my PHI: _____All records

Or Permission to release only: _____Chart Notes _____Test Results _____X-rays

Permission to release my PHI to: _____Only Medical requests

Or Permission to release to only: _____My Primary Care Physicians ____My Specialists _____Home Health ____ Physical Therapy Offices

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

1. _____
2. _____

I also allow the employees of West Coast Podiatry to 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

ACKNOWLEDGEMENT OF ACCESS TO NOTICE OF PRIVACY PRACTICES

I acknowledge that West Coast Podiatry Center, Inc. has given me the opportunity to read their Notice of Privacy Practices. I have also been offered my own copy, if I so desired.

_____ _____

Patient's Name (Please Print) **Date**

_____

Parent or Authorized Representative (if applicable)

_____

Signature of Patient

Questions and Complaints

If you believe that we may have violated your privacy rights, disagree with a decision made about access to your protected health information, want more information or have a questions or concerns, please contact us using the information below.

Contact: Stephen D. Lasday, DPM at West Coast Podiatry Center, phone number (941) 753-9599 in Bradenton, (941) 366-2627 in Sarasota or fax your request to (941) 755-0261.

You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with their address upon request.

"We support your right to protect the privacy of your health information."