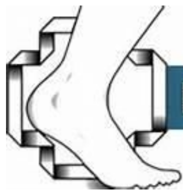

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5141 Deer Park Dr 1C
New Port Richey Fl, 34653
Office:727-847-240 Fax:727-841-0567

Dr. David Allen, DPM
Dr. David Collom, DPM
Dr. Nahed Bolis, DPM

5463 Commercial Way
Spring Hill, Florida 34606-1110
Office: 352-596-3338Fax:352-597-3986

PATIENT INFORMATION

Patient Name: ____ Today's Date: ___________________

Home Address: ____

City: __________________________ State: ______ ZIP: __________________

Home Phone #: ___________________________ Cell Phone #: _________________________________

Work Phone #: ___________________________ Email address: _________________________________

Date of Birth: ________________ Male: ____ Female: ____ Social Security #: __________________

Pharmacy: ________________________ Address: ____

Pharmacy Phone #: _______________________________________

Primary Care Physician:_____________________________________ Date Last Seen:________________

INSURANCE INFORMATION

Primary Insurance: ____

Secondary Insurance: ____

EMERGENCY CONTACT

Name:________________________________ Phone#:_____________________Relationship:_______________

REASON FOR VISIT

Complaint: ____

How Did Problem Develop? ____

Prior Treatment for Problem: ____

Past Medical History: Check all that apply to you:

___ Angina __Asthma __ Bladder Infection __Bleeding ___ Blood Pressure (High) __ Burning Urination

___Cancer __Cholesterol __COPD __Coronary ___Diabetes __Glaucoma ___Gout __ Jaundice/Hepatitis

__Emphysema __ Kidney Disease __ Lung Blood Clots ___ Stroke ___ Stomach Ulcer __Thyroid Disease __Weight Loss __Pneumonia __Phlebitis ____ Other:____

Past Surgeries:

____

____

Allergies:

____

____

Review of Systems: Check all that apply to you:

___ Back Problems ___ Chest Pain___ Dizziness___ Eye Problems___ GI Problems ___Headaches

___ Hearing Problems ___ Heart Problems___ Respiratory Problems___ Swelling of ankle/feet ___Urinary Frequency

Current Medications Name/Dose

________________________ ________________________

________________________ ________________________

________________________ ________________________

________________________ ________________________

X____Date:_______________

Signature: **Patient is giving consent to request Rx History**

Family History: **Please circle one**

____ Arthritis	Relative: ____________________	Deceased	Alive
____ Cancer	Relative: ____________________	Deceased	Alive
____ Diabetes	Relative: ____________________	Deceased	Alive
____ Gout	Relative: ____________________	Deceased	Alive
____ Heart	Relative: ____________________	Deceased	Alive

____ High Blood Pressure Relative: ________________________ Deceased Alive

FOOT & ANKLE Medical Center

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Dr. David Allen, DPM
Dr. David Collom, DPM
Dr. Nahed Bolis, DPM

5141 Deer Park Dr 1C
New Port Richey Fl, 34653
Office: 727-847-2406 Fax: 727-841-0567

5463 Commercial Way
Spring Hill, Florida 34606-1110
352-596-3338 = Office 352-597-3986 = Fax

RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION FOR TREATMENT

I authorize the release of any information necessary to process an insurance claim and to process payment of insurance benefits directly to David M Allen, DPM. I also authorize the release of medical information to physicals who participate in my care to ensure the continuity of my care. I authorize David M Allen, DPM/David S Collom, DPM tp treat me and perform procedures which may include the administering of medicine and local anesthetics. A photocopy of this authorization shall be considered an original document and effective with the date noted.

____ ____________________

Signature Date

DESIGNATED INDIVIDUALS TO RECEIVE MEDICAL INFORMATION

I authorize discussion and release of my general medical information, including treatment, condition, diagnoses and payment with:

Name:___________________________ Relationship:___________________ Phone#:______________________

Name:___________________________ Relationship:___________________ Phone#:______________________

Name:___________________________ Relationship:___________________ Phone#:______________________

ACKNOWLEDGEMENT OR RECEIPT OF PATIENT PRIVACY RIGHTS AND HIPPA PRACTICE

I have received, read, and understand the Patient Privacy Rights, and the HIPPA Practice rules.

____ ____________________

Signature Date

ACKNOWLEDGMENT OF RECEIPT OF OFFICE GUIDELINES AND PAYMENT POLICY

I have received, read and understand the Office Guidelines and Payment Policy and agree to abide by the terms noted therein.

____ ____________________

Signature Date

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Dr. David Allen DPM
Dr. David Collom DPM
Dr. Nahed Bolis, DPM

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Patient Questionnaire

Patient Name: ____ Date:___________________

D.O.B:_________________

Height:_________________

Weight: ________________

Tobacco Use (Circle Answer)

Never Smoked Former Smoker Currently Smoke: Cigarettes/Cigar/Pipe/Chew/Dip

And if so how much:________________

Alcohol Use: (Circle Answer)

None Beer:_______________ How Much:______________

Wine:_______________ How Much:______________

Liquor:______________ How Much:_______________

Vaccines: (Circle Answer)

Influenza (Flue Shot)**: Yes / No**

Pneumonia Vaccines**: Yes / No**

If you are a Diabetic do you know your last Hemoglobin A1C:___________

Date of results and name of Lab:______________________

Office Staff Use Only:

Blood Pressure:	Pulse
DM Exam: Yes / No	Fall Risk:

Signature of Assistant:

Fall Risk Assessment

Patient Name:______________________________ Date:_______________ D.O.B_____________________

Do You have any dizziness, confusion and or disorientation?	None (0)	Mild-Mod (2)	Interfered with daily life (4)		
History of falls or accidents in the past 12 months?	None (0)	1-2 falls near falls (2)	3 or more falls (9)		
How is your vision or hearing status?	Normal (0)	Poor w/ o Aids (2)	Legally blind or deaf (4)		
What is you sleeping status?	Normal (0)	Disturbed sleep (1)	Lack of sleep (2)		
Gait and Balance issues?	Normal (0) Pain and instability walking (1) Requires assistance(1) Decrease coordination (1) Pain and instability standing (1) jerking or instability (2)				
How is your range of motion and strength in feet and legs?	Normal (0)	Limited motion in feet/ankle (2)	Ankle instability or weakness(4)		
Meds, opiates, antihistamines, hypnotics, diuretics, sedatives, blood pressure meds?	None (0)	1-2 of these Medications (2)	3 or more of these Medication (4)		
Neurological Disorder including: peripheral Neuroapthy, MS, Parkinson's ,Drop foot, Sciatica ,ALS	None (0)	1-2 Presents (2)	3 or more president (4)		
Other predisposing factor: Amputation Vertigo, Arthritis, seizures, short limb, CVA, Obesity , joint replacement	None (0)	1-2 Presents (2)	3 or more president (4)		
Get up and Go?	Able in asingle motion (0)	Rise after 1 push (1)	Multiple attempts to rise (4)	Cannot maintain normal gait (4)	No walking (4)
Nightly Urination	None (0)	1-2 trips bathroom (1)	3 or more trips to bathroom (2)		
How is your judgment?	Normal 0)	Slow or impaired (1)			
Do you have proper footwear?	Proper foot ware(0)	Old or ill fitted shoes (2)	Doesn't(2)		
Living Surrounding?	Familiar (0)	Recent Move (2)			

Foot pathology exam corns, calluses, deformities, long nails	None (0)	1-2 issues (1)	3 or more (2)
Assessment: Walker/cane	Low risk of falls 0-5	Medium 6-10	High score 10

Sign: