Ridgefield Podiatry Associates
Henry S. Gross, DPM
Norman Gross, DPM

80 Grove Street
Ridgefield, CT 06877
(203) 438-2316

PATIENT INFORMATION:

Last Name: _____ First: _____ Middle Initial: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Sex: _____ Marital Status: _____ E-Mail Address: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Phone: _____

Work Phone: _____ Best Time/Place to Call: _____

WHOM MAY WE THANK FOR REFERRING YOU?

Newspaper / Yellow Pages / Website / Family / Friend / Physician / Other: _____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

PRIMARY CARE PHYSICIAN:

Dr. _____ ***Exact Date of Last Visit:** _____

Address/Location: _____ Phone: _____

Are you under regular care for any specific problem? _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone: _____

PATIENT EMPLOYER INFORMATION:

Occupation: _____

Employer: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION:

Who is financially responsible for this account? _____

Primary Insurance: _____ Insured Name: _____

Date of Birth: _____ Relationship to Patient: _____

Secondary Insurance: _____ Insured Name: _____

Date of Birth: _____ Relationship to Patient: _____

PLEASE PRESENT YOUR INSURANCE CARD AND PHOTO I.D. (A copy will become part of your medical record)

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FOOT HEALTH INFORMATION:

What is your current foot/ankle problem? (Be Specific): _____

_____ **Right / Left / Both**

When did it begin? _____

How have you treated this problem so far? _____

Have you seen another doctor for this problem? _____ If so, whom? _____

Have you ever seen a foot doctor? _____ If so, whom? _____

Shoe Size: _____ Height: _____ Weight: _____

MEDICAL HISTORY: (Please check all that apply)

Major Disease:
- □ Diabetes
- □ High Blood Pressure
- □ Bleeding Disorders
- □ Heart Attack
- □ Stroke
- □ Cancer _____
- □ Hepatitis
- □ Thyroid Problems
- □ Liver Disease
- □ Gout
- □ Tuberculosis

HEENT:
- □ Headaches
- □ Blurred Vision
- □ Double Vision
- □ Hearing Loss

Respiratory:
- □ Asthma
- □ Lung Disease
- □ Shortness of Breath

Psychological:
- □ Anxiety
- □ Depression

Vascular:
- □ Varicose Veins
- □ Poor Circulation
- □ Night Cramps
- □ Leg Ulcers
- □ Blood Clots

Arthritis:
- □ Back Pain
- □ Joint Pain
- □ Pain in Hands
- □ Pain in Feet

Gastrointestinal:
- □ Nausea
- □ Vomiting
- □ Ulcers

Podiatric Conditions:
- □ Corns/Calluses
- □ Numbness in Feet
- □ Bunions
- □ Night Cramps
- □ Heel Pain

Other:
- □ _____

DIABETICS: (Please answer the following questions)

How many years have you been diagnosed as a diabetic? _____

Blood sugar checks: How many times each day? _____ Average reading? _____

MEDICATIONS: (Please provide us with an updated list of your medications)

	Medication Name	Dose
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____

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ALLERGIES: (Please check all that apply and **list the type of reaction** you have)

□ Penicillin;_____
□ Novocaine;_____
□ Codeine;_____
□ Adhesive Tape;_____
□ Sulfa Drugs;_____
□ Iodine;_____
□ Latex;_____
□ Other;_____

PREVIOUS SURGERIES AND DATES:

1. _____
2. _____
3. _____
4. _____
5. _____

PREVIOUS HOSPITALIZATIONS AND DATES:

1. _____
2. _____
3. _____
4. _____
5. _____

SOCIAL HISTORY: (Please check all that apply)

□ Tobacco Packs per day? _____ How many years?_____
□ Alcohol Usage: _____
□ Exercise How often: _____
□ Pregnant Due Date: _____

FAMILY HISTORY / FAMILY MEMBER: (Please check all that apply)

□ Arthritis; _____
□ Cancer; _____
□ Diabetes; _____
□ Foot Problems; _____
□ Heart Disease; _____
□ High Blood Pressure; _____

ASSIGNMENT/RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage stated above and assign to Ridgefield Podiatry Associates all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance, and I may be billed for additional costs incurred in the collection of these accounts. I understand that it is my responsibility to know and understand my insurance plan.

I hereby authorize Ridgefield Podiatry Associates to release any private health information necessary in treatment, payment or health care operations. I authorize the use of this signature on all insurance claim submissions. I understand I may revoke this release only in writing. I understand that this office does leave voicemail messages if they are unable to contact patients, unless instructed in writing not to do so.

I certify that the information I have provided Ridgefield Podiatry Associates is true and correct to the best of my knowledge.

I give permission to Ridgefield Podiatry Associates to administer and perform such procedures as may be deemed necessary in my diagnosis and/or treatment on this visit as well as subsequent visits.

Signature of Responsible Party: _____ **Date**: _____