North Stamford Podiatry Associates
Henry S. Gross, DPM
Charles J. Gross, DPM

111 High Ridge Road
Stamford, CT 06905
(203) 322-4199

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;____________________
- ☐ Sulfa Drugs;____________________
- ☐ Novocaine;____________________
- ☐ Iodine;____________________
- ☐ Codeine;____________________
- ☐ Latex;____________________
- ☐ Adhesive Tape;____________________
- ☐ 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; ____________________
- ☐ Foot Problems; ____________________
- ☐ Cancer; ____________________
- ☐ Heart Disease; ____________________
- ☐ Diabetes; ____________________
- ☐ High Blood Pressure; ____________________

ASSIGNMENT/RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage stated above and assign to North Stamford 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 North Stamford 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 North Stamford Podiatry Associates is true and correct to the best of my knowledge.

I give permission to North Stamford 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**: ____________________