

HOWARD J. TZORFAS, D.P.M.
SURGEON PODIATRIST/FOOT SPECIALIST

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10 BRASS CASTLE ROAD
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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: _____ Home Phone: _____
Work Phone: _____ Cell Phone: _____

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 a 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)

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, when? _____

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:

- Swollen Feet/Legs
- Varicose Veins
- Poor Circulation
- Night Cramps
- Leg Ulcers
- Blood Clots
- Discoloration Legs/Feet

Arthritis:

- Back Pain
- Joint Pain
- Pain in Hands
- Pain in Feet

Gastrointestinal:

- Nausea
 - Vomiting
 - Ulcers
- Podiatric Conditions:**
- Corns/Calluses
 - Numbness in Feet
 - Bunions
 - Heel Pain

Other:

- _____
- _____

 Latex Allergy **ALLERGIES:** (List any medication allergies)**ADVANCED DIRECTIVE:**Do you have a living will or advanced directive? Yes No**SOCIAL HISTORY:** (Please check all that apply)
 Tobacco Packs per day? ____ How many years? ____ Pregnant
 Alcohol Usage: _____ Due Date: _____
MEDICATIONS: (Please provide us with an updated list of your medications)

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

ASSIGNMENT/RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage stated above and assign to Dr. Tzorfas 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 Dr. Tzorfas' office 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 Dr. Tzorfas' office is true and correct to the best of my knowledge.

I give permission to Dr. Tzorfas and staff 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:** _____