Dr. Rosa C. Roman

ANKLE AND FOOT CENTER

977 Broad Street Bloomfield, NJ 07003 Tel: 973-338-1111 / Fax: 973-338-1119

website: healthyfeetforlife.com

PATIENT DATA

Date:		DOB:	
Name:			
Address:			
Home Phone:		Social Security Number:	
Cell Phone:		email:	
Work Phone:			

Marital Status: Single Married Widowed Separated Divorced

If Child, Parent's Name:			
Occupation:		Employer:	
Employer Address:			

Name of Spouse:			
DOB:		Occupation:	
Employer:			
Employer Address:			
Business Phone:		Spouse Cell:	

Primary Insurance Carrier:			
Subscriber's name:			
Insurance ID #:		Group #:	
Ins. Carrier Address:			
Ins. Carrier Phone #:			

Secondary Insurance Carrier:			
Subscriber's name:			
Insurance ID #:		Group #:	
Ins. Carrier Address:			
Ins. Carrier Phone #:			

I HEREBY AUTHORIZE RELEASE OF INFORMATION TO FILE WITH MY INSURANCE CARRIER FOR CLAIMS. I ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR INDICATED ON THE CLAIM AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE.

Signature: Date:

Please note that we will charge a **$50 NO SHOW FEE** for failure to keep appointments or for cancellations **NOT** made within a **24-hour period**. We appreciate your understanding.

I give my consent to Dr. Rosa Roman to transmit electronically any medication prescribed to me to my named pharmacy. Also, I agree to allow Dr. Roman to request from my pharmacy electronically a copy of my medication profile.

Name:			
DOB:		Date:	
Pharmacy Name:			

MEDICATION LIST

Patient Name:

DOB:

List ALL MEDICATIONS you are taking (prescription, over-the-counter or herbal).

Pharmacy Name:

Address:

Phone:

MEDICATION	DOSAGE	HOW OFTEN TAKEN / CONDITION TAKING FOR

MEDICAL INFO

Name:			
DOB:		Date:	
Referred by (physician's name):			

CHIEF COMPLAINT / REASON FOR YOUR VISIT TODAY:
MEDICAL HISTORY:
SURGICAL HISTORY:
ALLERGIES (including Medication allergies):
SOCIAL HISTORY / SPORTS / HOBBIES:
FAMILY HISTORY:

Mother - Living / Deceased:		Cause of Death:	
Father - Living / Deceased:		Cause of Death:	

Do you smoke?	How many per day?	If past smoker, stop date?	Do you drink?

MEDICAL HISTORY (part 1)

	YES	NO
Are you in good health?		
Any change in your health within the past year?		
Are you under the care of a physician?		
When was your last physical examination?		
Name and address of physician:		
Have you been hospitalized or had a serious illness within the past 5 years?		
If yes, what was the illness or operation?		
Do you have or have you had any of the following diseases or problems?		
Rheumatic fever or rheumatic heart disease?		
Congenital heart lesions?		
Cardiovascular disease (heart trouble, heart attack, coronary		
Do you have pain in the chest upon exertion?		
Are you short of breath after mild exercise?		
Do your ankles swell?		
Do you get short of breath when you lie down, or do you require extra pillows when you sleep?		
Allergy?		
Asthma or hay fever?		
Hives or skin rash?		
Fainting spells or seizures?		
Diabetes?		
Do you have to urinate more than 6 times a day?		
Are you thirsty much of the time?		
Does your mouth frequently become dry?		
Hepatitis, jaundice, or liver disease?		
Arthritis?		
Inflammatory rheumatism (painful swollen joints)?		
Stomach ulcers?		
Kidney trouble?		
Tuberculosis?		
Do you have a persistent cough or cough up blood?		
Low blood pressure?		
Venereal Disease (syphilis, gonorrhea)?		
AIDS?		
Other?		
Have you had abnormal bleeding associated with previous		
Do you bruise easily?		

MEDICAL HISTORY (part 2)

	YES	NO
Have you ever required a blood transfusion?		
If yes, explain the circumstance:		
Have you had surgery or x-ray treatment for a tumor growth or other conditions of feet or ankles?		
Are you taking any of the following medications?		
Antibiotics and sulfa drugs?		
Anticoagulants (blood thinners)?		
High blood pressure medicine?		
Cortisone?		
Tranquilizers?		
Aspirin?		
Insulin, Tolbutamide, Orinase or similar drug?		
Digitalis or drugs for hearing trouble?		
Nitroglycerin?		
Other?		
Are you allergic or have you reacted adversely to the following:		
Local anesthtics?		
Penecillin or other antibiotics?		
Sulfa drugs?		
Barbiturates, sedatives, or sleeping pills?		
Aspirin?		
Iodine?		
Tape?		
Other?		
Have you had any serious trouble associated with any previous foot or ankle treatment?		
If yes, explain...		
Do you have any desease, condition or problem not listed below?		
If yes, please explain...		
(Women) Are you pregnant?		

Signature:

Date: