CARLOS F SILVA D.P.M. , P.C.
Podiatric Medicine – Foot surgery
ABPOPPM * APWCA
WWW.SILVAFOOTCARE.COM
FASTFUNNYFEET@AOL.COM

WOODHAVEN FOREST HILLS EAST MEADOW 718-805-3338 718-441-4872 FAX

Today's Date _____

Patient's Name _____ AGE _____ Male / female

Address _____Apt #_____town_____state____ zip code___

Phone # home ( )_____ Work ( ) _____

Cell ( ) _____ S S # _____ date of birth _____

E-mail address _____@ _____ **Preffered method of being contacted**: Mail, Phone E-Mail

Primary Language Spoken: English, Spanish, Other _____

Race _____ Ethnic Background

_____

Name of referring person _____ Phone # _____

Name of emergency contact person _____ phone # _____

Medical Doctor ( ) _____ UPIN # _____ NPI # _____

Address _____town_____state_____zip code_____

Phone # ( ) _____ Fax ( ) _____date last seen _____

Medical Insurance Medicare GHI BCBS CIGNA ELDERPLAN HIP OTHER _____

I.D. # _____ Group # _____ copay _____

deductible _____Payor ID # _____

Primary Name on Insurance Plan: self ___ spouse____ parent ___ Date of birth _____

Other Medical Insurance GHI BCBS AARP MEDICAID OTHER _____

ID # _____ Group # _____ COPAY _____

By signing below, I agree to the following:

Assign of Medical benefits to CARLOS F. SILVA DPM, PC
Certify that all the information that I disclose is true and correct to the best of my knowledge.
I will notify the Doctor of Any changes in my health status or insurance information.
I understand that I am financially responsible for any balance due on my account
I acknowledge that I was given the opportunity to read Notice of Private Practice if I choose too.
I Give Carlos F. Silva DPM, PC permission to diagnose and administer treatment to my feet.
I give Carlos F. Silva DPM, PC permission to take photographs of my feet if necessary.

Pt's / Guardian's Signature_X_____Date_____

CARLOS F SILVA D.P.M. , P.C ***Page 1***
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Patient Intake Questionnaire

place of service _____

Name: _____ Today's Date: _____

Reason for Visit:_____

Current Symptoms: (**Circle** all that apply)

Nails Ingrown Nail Infected ingrown Nail

Corns Callus Foot Pain Swelling Tenderness Discoloration

Diabetic Foot Care Numbness Tingling Burning Sensation

Foot / Ankle Injury Sprain Foot / Ankle Limping

Itching Dry Skin Athlete's Feet Warts

Heel Pain Arch Pain other _____

Date of Injury or Onset of Current Illness: (circle) Days Weeks Months

Auto Accident Work Related Sports Injury Illness Related Problem Unknown

Are You using a Cane, Crutch Walker ? Wheel Chair? Home Bound ? Bed Bound? Other

Did You Come to the office by Walk, Car, Bus Cab, Ambulette ? Seen @ Home?

Are You Accompany By any one? Yes___ NO ___ HHA, Family, Friend Other ____

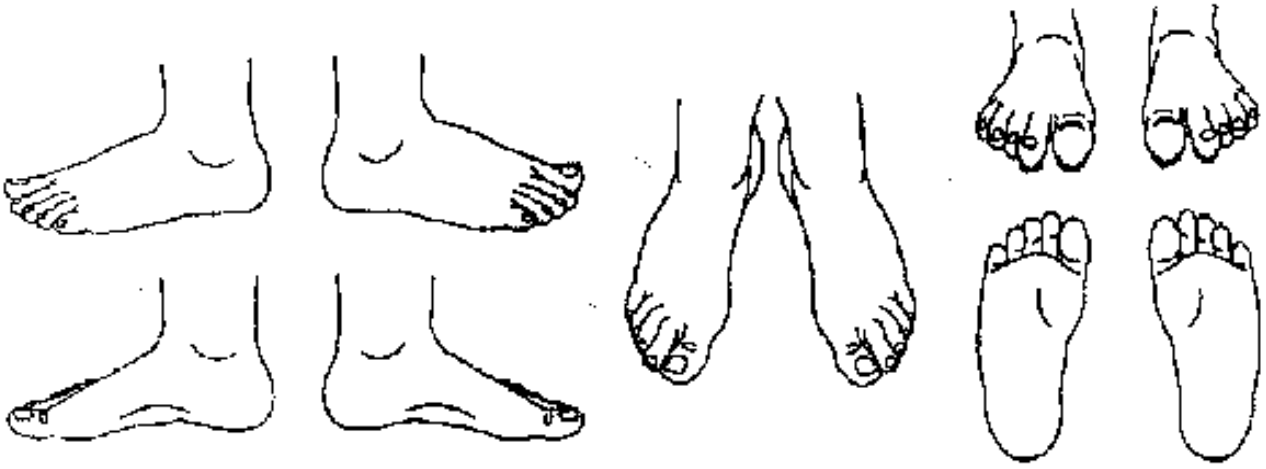
Severity of Pain **[ ]** Severe [ ] Moderate [ ] Mild [ ] Slight

Frequency of Pain **[ ]** Constant [ ] Frequent [ ] Occasional [ ] Intermittent

Have you been treated for this condition in the past? Yes No When? By Who ?

What make the condition worse**?** Walking Standing Shoes Hot Cold Other ____

List All **SURGERY / PROCEDURES** have you had**?** _____



NAME _____ **PAGE 2**

MEDICAL HISTORY

Age _____HEIGHT _____ WEIGHT _____LBS Male / Female

BLOOD PRESSURE _____ // _____ HEART RATE_____

(**Circle all that apply**)

DIABETIC INSULIN / NON – INSULIN HOW MANY YEARS _____
BLOOD SUGAR IN THE MORNING ___

POOR CIRCULATION ARTHRITIS HIGH BLOOD PRESSURE

GOUT DYALISIS STROKE CANCER OSTEOPOROSIS

OBESITY HEART DISEASE MS OTHER _____

Family History Of _____

Allergic to Any Medications **?** No ____ Yes _____, WHAT _____

Medications: (USE NEXT PAGE TO LIST ALL **)** _____NONE

Tell us about Social Activities:

Retired? YES ____ NO____ **Student?** YES ____ NO _____
Work? YES ____ NO _____ Type of Work _____
Smoke Cigarettes: YES ____ NO ____(#) packs per day / ____ # of Years
Stop Smoking? How Many Years Ago _____ **Drink Alcohol**: YES ____ NO _____
Recreational drug use? YES ____ NO _____ **Exercise:** YES ____ NO _____
Pregnant: YES ___ NO____ # of Months _____

SHOE SIZE _____Width _____

SHOE TYPE: dress shoes oxford heels flats sneakers
Loafers boots Sandals other

Patient's Signature **X**_____**Reviewed By:**_____

MY MEDICATION LIST

Patient Name: _____ Date: _____

Date of Birth: _____

Please list all drugs you are currently taking. Drugs include prescription and over-the-counter medications, herbal products, nutritional supplements, and recreational drugs. ***Bring this list with you to your first appointment.***

Name of Drug?	Strength of Drug?	How Often Do You Take?	Why Do You Take This Drug?	Who Prescribed Drug? (if prescription)

Do you have any allergies? ____ Yes ____No

If yes, please list:

_____

_____