OKSANA BUTTITA PODIATRY
Foot & Ankle Medicine and Surgery

PODIATRY NEW PATIENT FORM

Today's date: _____

Patient Name:_____ **Referred By**:_____

DOB: _____ **Phone number:** _____ **Email:**_____

Address:_____

Emergency contact name: _____ **phone:** _____

How would you like to be reminded about your future appointments (please circle one): TEXT / VOICE

Primary doctor:_____ **Last Visit (date) :**_____

Your height: _____ **Your weight**: _____ **Your shoe size**:_____

Why are you here today? (include date of injury if applicable)

_____

What medications are you allergic to?_____

What type of reaction did you experience?_____

What medications are you taking?_____

_____

_____

Please list all your medical conditions?_____

_____

_____

_____

What surgeries have you had in the past?_____

_____

_____

What serious conditions do your parents/siblings/children have? (e.g diabetes, cancer, high blood pressure, heart disease)_____

Do you smoke? Yes / No How many packs per day? ___ How many years?_____

Did you smoke in the past? Yes / No

Amount of alcohol you drink every week?_____

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Health review: Please circle anything that applies to you

General: Fever – Chills – Weakness - Weight gain – Weight loss

Skin: Itching – Rash – Sores – Lumps – Ulcer – Moles

HEAD: Trauma – Headaches

EYES: Glasses – Blurred vision – Vision loss – Cataracts – Glaucoma

EARS: Hearing loss – Vertigo – Ear ache

NOSE: Discharge – Stuffiness – Itching

MOUTH/THROAT/NECK: Sore throat – Swollen neck – Coughing

CARDIAC: Hypertension – Palpitations – Leg swelling – Irregular heart rhythm

RESPIRATORY: Shortness of breath – Cough – Wheezing – Asthma – History of tuberculosis

GASTROINTESTINAL: Nausea –Vomiting – Heartburn – Diarrhea – Constipation – Abdominal pain

URINARY: Frequent nighttime urination – Blood in urine – Pain with urination – Incontinence

VASCULAR: Pain in calves while walking – Pain to legs at rest – Varicose veins – Thrombosis

NEUROLOGIC: Loss of sensation – Numbness to hands/feet – Tremors – Seizures

ENDOCRINE: Thyroid problems – Heat/Cold intolerance – Excessive sweating

PSYCHIATRIC: Anxiety – Depression

OTHER PROBLEMS NOT LISTED ABOVE:_____

FOR PATIENTS WITH DIABETES:

*Last HBA1c?*_____

Who is your endocrinologist: _____

Are you wearing diabetic shoes: Yes / No *Date you last received shoes* _____

The information provided here is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition with x-ray, examination or photographs of infections as necessary.

Patient Signature:_____ **Date:** _____

I have personally reviewed the above information.

Physician Signature: _____

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AUTHORIZATION FOR TREATMENT

I hereby give my consent for Dr. Oksana Buttita to render medical services, lab, x-rays, etc. I authorize any holder of medical and or other information about me to be released to assist the processing of my medical claim.

_____ _____

Patient name (print) ***Date***

_____

Guardian name (print)

Assignment of Insurance Benefits Treatment / Financial responsibility

I hereby request that my insurance carrier make payments directly to Dr. Oksana Buttita for any and all services rendered by this office. I, the undersigned, understand that Dr. Oksana Buttita will bill my insurance carrier for services rendered upon verification of coverage by my insurance company. I also understand that should my insurance company fail to render payment for services received, I am fully responsible for the payment of any and all deductible and / or co-payment amount, and for charges incurred that are not subject to any payment by my insurance company.

Should it be necessary for Dr. Oksana Buttita to engage professional collection effort, I will be held responsible for any and all additional cost of collections, including but not limited to agency fee which constitutes 100 % of unpaid patient balance, attorney fees, court costs and interest.

I further understand that if injury results in litigation against a third party, this in no way relieves me of my obligation to pay for the services rendered. I understand that payments of the fees are not contingent upon settlement of litigation. However, I hereby instruct my attorney to pay the bill in full directly from the proceeds from any settlement or judgment rendered on my behalf

Insurance payments are based on your policy. Upon completion of your service, when your insurance company has paid its portion, the remaining balance will be forwarded to the patient.

(SHOULD YOU HAVE ADDITIONAL INSURANCE PLEASE ADVICE THE OFFICE)

Our billing to your insurance carrier is done as a courtesy to our patient.

I understand the above financial commitment is due to me upon rendering of services.

_____

Signature