ABSOLUTE MEDICAL CARE/ ABSOLUTE FOOT AND ANKLE CLINIC
PODIATRIST FIRST VISIT FORM

DATE_____ **Patient Full Name:**_____

Date of Birth: _____Sex: _____ SSN:_____

Patient Address: _____

City, St, Zip: _____

Email Address:_____

Race / Ethnicity: (Check One) 1American Indian or Alaska Native ☐2. Asian☐3. Black or African American☐
4. Hispanic or Latino☐5. Native Hawaiian or Other Pacific Islander☐6. White☐7. Other_____

Preferred Language_____

Patient Home Phone: _____Cell:_____

Emergency Contact Name: _____Relationship:_____Phone:_____

Family Doctor's Name:_____ Phone:_____

Address _____ Last Visit Date_____

Chief Complaint (reason for seeing a Podiatrist) _____

Have you ever been to a Podiatrist Before – Yes ☐ No ☐

If Yes, please list: Name _____Date of Last Visit _____

Is there any personal of family history of diabetes – Yes ☐ No ☐

Your occupation _____

Cigarette/ Tobacco Use – Yes ☐ No ☐ Years Smoked _____

Athletic activities in which you participate (please list and indicate frequency) _____

_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes ☐ No ☐	Epilepsy	Yes ☐ No ☐	Rash	Yes ☐ No ☐
Allergies to Anesthetics	Yes ☐ No ☐	Eye Problems	Yes ☐ No ☐	Respiratory Disease	Yes ☐ No ☐
Allergies to Medicine/Drugs	Yes ☐ No ☐	Fainting	Yes ☐ No ☐	Rheumatic Fever	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Foot or Leg Cramps	Yes ☐ No ☐	Shortness of Breath	Yes ☐ No ☐
Angina	Yes ☐ No ☐	Gout	Yes ☐ No ☐	Sinus Problems	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	Headaches	Yes ☐ No ☐	Special Diet	Yes ☐ No ☐
Artificial Heart Valves or Joints	Yes ☐ No ☐	Heart Desease	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Hemophilia	Yes ☐ No ☐	Swelling of Ankles, Feet	Yes ☐ No ☐
Back Problems	Yes ☐ No ☐	Hepatitis or Jaundice	Yes ☐ No ☐	Swollen Neck Glands	Yes ☐ No ☐
Bleeding Disorders	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐	Tired Feet	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Kidney Problems	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐
Chemical Dependency	Yes ☐ No ☐	Liver Disease	Yes ☐ No ☐	Ulcers	Yes ☐ No ☐
Chest Pain	Yes ☐ No ☐	Low Blood Pressure	Yes ☐ No ☐	Varicose Veins	Yes ☐ No ☐
Chronic Diarrhea	Yes ☐ No ☐	Neuropathy	Yes ☐ No ☐	Venereal Disease	Yes ☐ No ☐
Circulatory Problems	Yes ☐ No ☐	Phlebitis	Yes ☐ No ☐	Weight loss unexplained	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Psychiatric Care	Yes ☐ No ☐	Taking Contraceptives	Yes ☐ No☐
Ear Problems	Yes ☐ No ☐	Radiation Treatment	Yes ☐ No ☐		

PREVIOUS SURGERIES / HOSPITALIZATIONS_____

_____

_____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins (bring in a list if present)_____

_____

_____

Pharmacy Name(s) _____**Pharmacy Phone(s)** _____

ALLEGRIES

Adhesive / Tape	Yes ☐ No ☐	Local Anesthetics	Yes ☐ No ☐
Anticoagulant Therapy	Yes ☐ No ☐	Novocaine	Yes ☐ No ☐
Aspirin	Yes ☐ No ☐	Penicillin	Yes ☐ No ☐
Codeine	Yes ☐ No ☐	Seafood	Yes ☐ No ☐
Demerol	Yes ☐ No ☐	Sulfa	Yes ☐ No ☐
Iodine	Yes ☐ No ☐	Other _____	

INSURANCE INFORMATION
(Please have all Insurance Cards and Id with you during visit)

InsuredName_____
Primary Insurance Company Name_____
Insurance ID# _____Group #_____
Claims Address _____City State Zip_____

SUPPLEMENTAL/ SECONDARY INSURANCE

InsuredName_____
Secondary Insurance Company Name_____
Secondary Insurance ID# _____ Group#_____
Claims Address_____CityStateZip_____

PATIENT CONSENT FOR TREATMENT

I, _____hereby give my permission to Dr. Rabinovich D.P.M. and his staff and associates to administer treatment and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot-ankle condition(s).

AUTHORIZATION TO RELEASE INFORMATION

I, _____ hereby authorize Dr. Rabinovich to release any medical information pertaining to my treatment and permit any insurer to inspect my medical records in connection with charges arising from this treatment in accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all its provisions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

FINANCIAL POLICY:

I, _____hereby authorize payment of medical benefits to Dr. Rabinovich for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance, including co-pays, deductible, and non-covered services if any. If you do not have insurance, the total agreed upon with the doctor cost of your visit is required at the time of service. If you have a high deductible plan (over $500) with unmet deductible or you are receiving a non-covered service/procedure, a deposit payment will be required at time of service at office cash price fee schedule for procedures/DME received. Missed appointment fee is $40. Should you default on your required payment, collection action is possible.

_____I have read and accept the financial policy of Absolute Medical Care &Absolute Foot and Ankle Clinic. I authorize payment of medical benefits to the named provider for professional services rendered.

Patient Name: _____
Signature of Adult over 18: _____
Relationship to Patient: _____Date: _____