Rorick Podiatry PC

Dr. Gregory S. Rorick, DPM
Board Certified
Podiatric Medicine and Surgery

587 Main Street Suite 102B New York Mills, NY 13417 Phone 315-736-TOES (8637) Fax 315-736-3423

PATIENT INFORMATION Please print clearly and fill out completely – **BLACK INK ONLY** - Thank you.

First Name _____MI ____ Last Name _____ Male ❍ Female ❍

Patient Home Street Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone #( )_____ Cell Phone #( )_____Work Phone #( )_____

Pharmacy Name and Address: _____

Patient's *e-mail address:* [please print clearly] _____

The e-mail address will be used only for appointment reminders and the access to the patient portal.

Marital Status: Single ❍ Married ❍ Widowed ❍ Divorced ❍ Spouse/Partner Name _____

Patient Date of Birth _____/_____/_____ Age _____ Social Security Number _____-_____-_____

Patient Height _____'_____" Weight _____ Shoe Size _____

Patient Occupation _____ Employer Name _____ Employer Phone #( )_____

Emergency Contact Name _____ Phone #( )_____ Relationship_____

Race: American Indian or Alaska Native ❍ Asian ❍ Black or African American ❍ White ❍ Native Hawaiian or Other Pacific Islander ❍

If patient is a minor – provide name of parents or legal guardians _____

Address and phone # of parents or legal guardians (if different from above): _____

_____

Family Physician/Pediatrician (PCP) _____ Phone #( )_____ Date of last visit ____/____/____

REFERRAL INFORMATION

Google/Internet ❍ Friend/Family ❍ Insurance ❍ Facebook ❍ Doctor Referral (who?) _____❍ Other _____❍

PAYMENT AND INSURANCE INFORMATION – **PLEASE PRESENT YOUR INSURANCE CARD AND DRIVERS LICENSE UPON ARRIVAL**

Check here if no health insurance ❍

Full Name of Insured _____ Relationship to Patient _____

Insured SS# _____-_____-_____ Insured Date of Birth _____/_____/_____ Insured Employer _____

According to my insurance, I am responsible to pay a Co-Pay Amount $ _____ Deductible Amount $ _____

My insurance requires a referral from my PCP (primary care physician) before I see a specialist. Yes ❍ No❍

READ AND INITIAL EACH STATEMENT AND SIGN AND DATE AT BOTTOM

____ I certify that the information provided on this form is true and correct to the best of my knowledge.
____ I request that payments of authorized benefits be made on my behalf for any services furnished by Rorick Podiatry PC.
____ I authorize any holder of information about me to release any information needed to determine these benefits payable to related services to the insurance agent.
____ I recognize my financial obligation of any coinsurance, co-pays, or deductibles and non-covered services that may be required.
____ I have received a copy of Rorick Podiatry PC's financial policy and agree to abide by its guidelines.
____ I hereby give permission to Rorick Podiatry PC and any qualified staff to evaluate, diagnose, and treat my foot condition as may be deemed medically necessary.
____ I authorize Rorick Podiatry PC and qualified staff to leave test results, appointment reminders, scheduling, and business information via email, voice, and automated text reminders.
____ I have received a copy of the HIPPA Document and Privacy Policy and agree to abide by its guidelines.

Patient or Authorized Signature_____Date _____/_____/_____

If not patient, state relationship _____

Patient Name _____

MEDICAL HISTORY

Have you ever been treated for any of the following conditions?
Please √all that apply to you;

___ Acid Reflux	___ Hyperthyroidism
___ Anemia	___ Hypothyroidism
___ Arthritis	___ Irritable Bowel Syndrome
___ Asthma	___ Kidney Problems
___ Bleeding Disorders	___ Liver Disease
___ Blood Clots	___ Nervous Disorder
___ Cancer	___ Multiple Sclerosis
___ Depression	___ Muscle or Joint Pain
___ Diabetes	___ Peripheral Arterial Disease
___ Epilepsy	___ Parkinson's Disease
___ Fatigue	___ Phlebitis
___ Fibromyalgia	___ Poor Circulation
___ Headaches	___ Seizure Disorders
___ Heart Condition	___ Stomach Ulcers
___ Hepatitis	___ Stroke
___ High Cholesterol	___ Varicose Veins
___ HIV/AIDS	___ Other _____
___ High Blood Pressure	_____

MEDICATIONS

Are you currently on Blood Thinners? Yes ❍ No ❍

Please provide a printed list of your medications or list them below.

Name of Medication	Strength/Mg

ALLERGIES

Have you ever had any adverse side effects or allergies to:					
	Yes	**No**		**Yes**	**No**
Adhesive Tape			Metal/Jewelry		
Anticoagulants			Novocaine		
Anti-inflammatory medications			Penicillin		
Aspirin			Seafood		
Codeine			Sulfa		
Cortisone			Other antibiotics		
Iodine			Other pain medication		
Latex			**Other** _____ _____		

SURGERIES

Please list all surgeries	Approximate Date

SOCIAL HISTORY

Tobacco Use? (please circle): **Non Smoker** **Current Smoker** **Former Smoker –** how long ago did you quit? _____

Alcohol use? (please circle): **Yes** **No** If yes, quantity _____ daily _____ weekly _____ monthly
How often do you have 6 or more drinks on 1 occasion? (please circle): **Never** **Monthly** **Weekly** **Daily**

Drug use? (please circle): **Yes** **No** If yes, substance _____

PODIATRIC HISTORY

Have you ever been to a foot and ankle specialist before? (please circle): **Yes** **No**
What is your **chief foot complaint** for which you came to be treated? _____

_____

_____

When did it begin? _____ Did you receive treatment for this condition? **(please circle): Yes** **No**

If so, what type? _____

Circle the **degree of pain** you are currently experiencing: Minimal 1 2 3 4 5 6 7 8 9 10 Severe