Patrick J. Caputo, DPM **2017** **Douglas DeLorenzo, DPM**

Welcome to our Board Certified Podiatrists
Caputo Foot & Ankle Center & Holmdel Wound Care Center, LLC

Date_____

Name_____ _____ _____ **S.S. #** (_____-_____-_____)
(Last) **(First)** **(Middle)**

Address _____ _____ _____
(Street) **(City, State, Zip)** **(Years There)**

Primary Phone: _____ **Secondary Phone:**_____
Circle→ Home Cell Work **Circle→ Home Cell Work**

May we leave on message on your answering machine? Yes No

Birthdate _____/_____/_____ **Age**_____ **Marital Status:** (Single)(Married)(Divorced)(Separated)(Widowed)(Other)

Employer/School _____ **Occupation** _____ **How Long**_____

Emergency Contact_____**Phone** _____-_____-_____

E-mail _____

PHARMACY_____**ADDRESS**_____**PHONE**_____-_____-_____

Important! -- Subscriber/Policy Holder Insurance Info: (only if not same as patient)

Name _____ ***Birthdate*** ___/____/___***Relationship To Patient*** _____

Employer _____***Occupation*** _____***How Long*** ____ **S.S. #**(last 4 digits_____)

Family Physician – Dr. _____**Phone** _____-_____-_____

****Please Describe Your Foot/Ankle Problems:*** _____

_____

Patient Authorization:

- I request that payment of authorized Medicare or Insurance benefits be made either to me or on my behalf to Dr. Patrick J. Caputo (or any physician of Caputo Foot & Ankle Centers), for all services provided to me by these physicians or suppliers. I authorize any holder of medical information about me to release to the Health Care Financing Administration or my insurance and its agents any information needed to determine these benefits or the benefits payable for related services.
- **I authorize my insurance benefits be paid directly to the Doctor's Office.**
- **I am financially responsible for deductible, co-insurance & any non-covered services. All co-pays are due at time of service.**
- I give permission to the Doctor to examine and administer treatment and perform such general procedures, as he/she may deem necessary in the diagnosis and/or treatment of my condition.
- I understand that there are no guarantees associated with any working diagnosis or treatment.
- **Cancellation Policy**: We understand that there are times that you may need to cancel an appointment. Please do so within a 24 hr period. For repeat offenders a nominal charge may be applied.
- Notice of Privacy Practices is available in the Waiting Room and copies available upon request.

I HAVE READ AND AGREE TO THE ABOVE STATEMENTS:

Signature: _____ Date_____

Please Turn Page Over

Name_____ **Date:**_____

A. Please check and/or circle all that pertain to ***YOUR Medical History***:

_____ Diabetes (Glucose=_____A1c=_____)
_____ High Blood Pressure (Good control: Yes / No)
_____ Heart Disease, Stroke or on Blood Thinners
_____ Poor Circulation or Vascular Surgery
_____ Neuropathy, Burning or Pins& needles
_____ Wound Care Problems/Slow healing wounds
Yes / No Did you ever have a MRSA Infection?
_____ Anemia, Blood Disease, or Blood Clots
_____ Thyroid Condition
_____ Psoriasis
_____ Toenail Problems or Severe Athlete's Foot
_____Shoe Size & Common style :_____
Yes / No Are you a Current smoker?
Yes / No Prior Smoker; Quit when?_____

Height:_____ Weight_____

_____ Kidney Infection or Stones
_____ Poor functioning Kidney, Renal Failure, or Dialysis
_____Liver Disease, Cirrhosis, Fatty Liver or Hepatitis,
_____Stomach Ulcer or Gastritis/Hiatal Hernia
_____Emphysema/COPD/Recent Pneumonia
_____Asthma (what causes it):_____
_____Arthritis (what joints): _____
_____ Gout (When was last attack):_____
_____Fracture: Ankle/Foot or Severe Ankle Sprain
_____Severe back problems
_____Hip or Knee Joint Replacement
_____Balance Problems, Unsteady Walking, or Recent Fall
_____Anxiety, Depression, Seizures, or Nervous System Disorder
_____Cancer:_____
_____Skin Cancer (Part of Body):_____
_____(Other)_____

***Very Important**

B. CURRENT PRESCRIPTION MEDICATIONS (and OTC Meds)

Check if you brought Rx List (_____)

1) Rx_____ for_____
2) Rx_____ for_____
3) Rx_____ for_____
4) Rx_____ for_____
5) Rx_____ for_____
6) Rx_____ for_____

*) Other Vitamins, Minerals and OTC Products _____

C. Please list ALLERGIES and describe Allergic REACTION

Check if you brought Allergy List (_____)

Allergy:1)_____ Reaction _____
Allergy:2)_____ Reaction _____
Allergy:3)_____ Reaction _____
Allergy:4)_____ Reaction _____

D. HOSPITALIZATIONS and SURGERIES within past 10 years, or Any Minor Foot/Ankle Surgery or Injury

- _____ Year _____
- _____ Year _____
- _____ Year _____

E. How did you find out about Drs. Caputo/or Associates? Please check **all** that apply! Thank You.

Referred from Family Physician or Office Staff: Dr. _____
Referred from Other Doctor/Nurse/Therapist (name):_____
Referred from Friend/Relative (name)_____
Insurance List:_____ Hospital/Wound Care Center Referral:_____ Recognized the name/Good reputation:_____
Website/Internet: _____ Social Media:_____ Yellow pages:_____ Other:_____
Have you or has anyone in your family been treated in our office before? YES / NO Office use:
If yes, NAME? _____ Reviewed By_____