NEXT STEP Foot & Ankle

Date _____/_____/_____

Elie Mendelson, DPM
Michael J. Ball, DPM

9080 Kimberly Blvd Suite 7 · Boca Raton, FL 33434 · 561-483-4448 · www.nextstepboca.com

Name _____ Birthdate _____/_____/_____

Gender ☐ M ☐ F

Local Home Address _____

_____

Out Of Town Address _____

_____

Preferred phone # _____ ☐ Home ☐ Cell

Email address: _____

Providing an email address allows the patient electronic access to their Patient Health Record. This information is password protected and available only to the patient.

Preferred method of communication: ☐ Home phone ☐ Cell phone ☐ Email ☐ Snail mail

May we leave a voicemail? ☐ Yes ☐ No

With whom may we leave messages? ☐ Spouse/partner ☐ Daughter/son ☐ Aide ☐ Other: _____

Emergency Contact:

Name _____ Relationship _____

Phone # _____

How did you hear about us?

☐ Google ☐ Zocdoc ☐ Insurance ☐ Postcard ☐ Other Ad

☐ Doctor _____ ☐ Family/Friend _____ ☐ Hospital

Primary physician _____

List of medications (or provide list):

Name	Dosage

Pharmacy Name & Phone: _____

Allergies (check all that apply):

- ⬜ No Known Allergies
- ⬜ Penicillin
- ⬜ Aspirin
- ⬜ Latex
- ⬜ Sulfa
- ⬜ Other: _____
- ⬜ Codeine
- ⬜ Contrast dye
- ⬜ Topical iodine
- ⬜ Adhesive tape
- ⬜ Shellfish

Smoking status:

- ⬜ Never smoked
- ⬜ Currently smoke How much? _____
- ⬜ Previously smoked Quit date _____

Height _____

Weight _____

Shoe Size _____

When was your last flu shot? _____/_____/_____

Have you received a pneumonia vaccine? ⬜ Yes ⬜ No

Have you fallen in the last 12 months? ⬜ Yes ⬜ No

If yes, were you injured from the fall? ⬜ Yes ⬜ No

Medical history (check all that apply):

- ⬜ Acid Reflux
- ⬜ Anemia
- ⬜ Anxiety
- ⬜ Arthritis
- ⬜ Atrial fibrillation
- ⬜ Blood clots/DVT
- ⬜ Cancer: _____
- ⬜ CHF/heart failure
- ⬜ COPD
- ⬜ Crohn's/colitis
- ⬜ Depression
- ⬜ Diabetes (insulin)
- ⬜ Diabetes (non-insulin)
- ⬜ Fibromyalgia
- ⬜ Gout
- ⬜ Heart Attack
- ⬜ Hepatitis C
- ⬜ High blood pressure
- ⬜ High cholesterol
- ⬜ HIV/AIDS
- ⬜ Kidney disease
- ⬜ Liver disease
- ⬜ Low blood pressure
- ⬜ Neuropathy
- ⬜ Parkinson's
- ⬜ Psoriasis
- ⬜ Skin disorder
- ⬜ Stomach ulcers
- ⬜ Stroke
- ⬜ Thyroid disease

Surgical history (check all that apply):

- ⬜ Cardiac stents
- ⬜ Leg stents
- ⬜ Foot/ankle surgery: _____
- ⬜ Open heart surgery
- ⬜ Pacemaker
- ⬜ Other surgery: _____

The information I provided above is accurate and answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and/or office staff of any changes to this information.

Signature _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices and Authorization of Benefits
I acknowledge that I was provided a copy of the Notice of HIPAA Privacy Practices, and that I have (or have the opportunity to read if I so choose) and understand the Notice. I authorize payment of medical benefits to the practice named above. I authorize release of medical information necessary to process this claim. I authorize the doctor's office to retrieve my medication history. I understand that I am financially responsible for any balance due to my account. I understand that I will be responsible for a $50 no-show fee which will be assessed if I do not cancel or reschedule within 24 hours of my appointment. Additionally, I hereby consent to any treatment as deemed necessary by the doctor(s).

Patient name _____

Authorized Representative (if applicable) _____

Signature _____ Date _____