Paul Shapiro, D.P.M.
Diplomate American Board of Podiatric Surgery

Associated Podiatrists, P.C.
3330 N 2nd Street #100 Phoenix, Arizona 85012
(602) 264-1031 Fax: (602) 264-3864

Lindsey Westerhaus, D.P.M.

Date:_____ **File:**_____
(Fecha)

Name: _____ **MALE**____ **FEMALE** ____ **Marital Status: Married** ___**Single**___
(Nombre)

Birth Date: _____/_____/_____ **Age:** _____ **Social Security Number:** _____-_____-_____
(Fecha de Nacamiento) *(Edad)* *(Número del seguro social)*

Home (_____**)** _____ **Work (**_____**)** _____ **Cell (**_____**)** _____
(Telefono de Hogar) *(Telefono de Trabajo)* *(Telefono Cellular)*

Home Address _____ **Apt. #**_____
(Domicilio Particular)
City _____ **State** _____ **Zip** _____
(Ciudad) *(Estado)* *(Codigo Postal)*
Email: _____

Mailing Address (check if same) ☐ _____ **Apt. #**_____
(Dirección de envío) (Verifique si el mismo) ☐

City _____ **State**_____ **Zip**_____
(Ciudad) *(Estado)* *(Codigo Postal)*
Employment Information: Occupation_____ **Employer**_____
(Información de Empleador) *(Occupacion)* *(Empleador)*

Employer Address_____ **City**_____ **State**_____ **Zip**_____
(Lugar de Trabajo) *(Ciudad)* *(Estado)* *(Codigo Postal)*
Insurance Information: Primary Insurance _____ **ID #**_____
(Información de seguro) *(Seguro Primario)* *(Numero de Identificación)*

Policy Holder Name_____ **Social Security #**_____-_____-_____
(Poseedor de Póliza de seguros) (Número del seguro social)

Group # _____ **Date of Birth** _____/_____/_____ **Relationship to Patient** _____
(Numero de Grupo) *(Fecha de Nacamiento)* *(Relation de Paciente*)
Employer of Insurance Holder _____
(El Empleador de Poseedor de Seguro)

Secondary Insurance_____ **ID#**_____
(Seguro Secundario) *(Numero de Identificación)*

Policy Holder Name _____ **Social Security #**_____-_____-_____
(El Empleador de Poseedor de Seguro) *(Número del seguro social*)

Group #_____ **Date of Birth** ____/____/_____ **Relationship to Patient**_____
(Numero de Grupo) *(Fecha de Nacamiento)* *(Relation de Paciente*)
Employer of Insurance Holder_____
(El Empleador de Poseedor de Seguro)

Primary Care Physician:_____ **Last visit date:** _____

Race: African American__ **Caucasian**___ **Hispanic**___ **Asian**___ **Other**___ **Ethnicity: Hispanic/Latino** ___ **Other**___ **Refused/Not Reported** ___

How did you hear about our office? ☐ **Physician Referral** ☐ **Insurance Booklet** ☐ **Yellow Pages**
Cómo hizole se entera de nuestra oficina? *Su Doctor Primaria* *Libro de Seguro* *Pajinas Amarillas*
☐ **Internet** ☐ **Friend/Family** _____ ☐**Other**_____

Name _____ **File Number** _____

Please indicate if you have history of any of the following:

	YES		YES		YES
DIABETES Type I / Type II		GASTROINTESTINAL DISORDERS		CONGESTIVE HEART FAILURE	
CEREBRAL PALSY		CHARCOT ARTHROPATHY		MUSCULAR DYSTROPHY	
AIDS/HIV		CANCER		SLEEP APNEA	
ANGINA/CHEST PAIN		CHEMICAL DEPENDANCE		OSTEOPOROSIS	
DEPRESSION ILLNESS		BLEEDING DISORDERS		DEEP VEIN THROMBOSIS/DVT	
JOINT REPLACEMENT		HYPERTENSION/HIGH BLOOD PRESSURE		RESPIRATORYY DISORDERS	
ASTHMA		STROKE		PERIPHERAL VASCULAR DISEASE	
ALCOHOLISM		HEPATITIS/JAUNDICE		THROMBOPHLEBITIS	
DRUG ABUSE		THYROID DISEASE		RENAL/KIDNEY DISEASE	
RHEUMATOID DISEASE		GOUT		LYMPHADENOPATHY	
BACK PROBLEMS		LIVER DISEASE		OSTEOARTHRITIS	
ANEMIA		HIGH CHOLESTEROL		CELLULITIS	
CORONARY ARTERY DISEASE		SKIN DISORDERS _____		Neurologic Disorder (specify) _____	

(¿Indique por favor si usted ha tenido cualquiera del siguiente?)

Have you ever been treated for the Following Foot Conditions? *(¿Le Tiene fue jamás tratado para las Condiciones?)*

	YES		YES		YES
HEEL PAIN		CORNS/CALLUSES		ATHLETES FEET/RASH	
FLATFEET		WARTS		IN-GROWN TOENAILS	
CHILDHOOD FOOT DISORDERS		ULCERATIONS		FUNGAL NAILS	
BUNIONS		ANKLE INJURY		FRACTURE FOOT	
HAMMERTOES		HIGH ARCHED FEET		FRACTURE ANKLE	
DIABETIC NEUROPATHY		FOOT SURGERY		NEUROMA	

SOCIAL HISTORY

Do You Smoke? *Fuma?*	**YES**	
DO YOU CONSUME ALCOHOL? *Toma Bebidas Alcolocas?*	**YES**	
Are you Pregnant? *Son usted Embarazada?*	**YES**	

Family History: Is there a Family History of the following?
(La Historia familiar: ¿Hay una Historia Familiar del siguiente? Verifique)

	YES		YES		YES
Arthritis		Bleeding Disorders		Circulatory Problems	
Diabetes		Neurologic Disorders		Hammer Toes	
Cancer		Heart Disease		Bunions	
Flatfeet		Blood Clots/DVT/PE		Other_____	

Name _____File Number_____

Reason for Today's Visit_____

Surgical History/Cirugías: PLEASE LIST NONE (CIRLCE)

_____ _____

_____ _____

_____ _____

Hospitalization/Hospitalización: PLEASE LIST NONE (CIRLCE)

_____ _____

PHARMACY INFORMATION:
NAME: _____ CROSS ROADS: _____

Are you taking blood thinners? *Son usted tomando sangre thinners?*	**YES (Specify)**		**Coumadin/Warfarin**		**Plavix**	
			Aspirin		**Heparin**	

Medications: *Las medicinas:*	**Check if you have provided a list of your Medications** *Verifique si usted ha proporcionado una lista de sus Medicinas*	

PHONE # _____
CURRRENT MEDICATIONS: **OFFICE USE: INPUT INTO COMP: _____**

ALLERGIES: Are you Allergic or Sensitive to the following? *(Son usted Alérgico o Sensible al siguiente?)*

	YES		YES		YES		YES
Adhesive / Tape		Local Anesthetics		Morphine		NONE, I HAVE NO KNOWN ALLERGIES/ *NINGUNO, No TENGO ALERGIAS CONOCIDAS*	
Demerol		Novocaine		Anticoagulant Therapy			
Aspirin		Sulfa Drugs ex. Bactrim		Iodine/Betadine			
Penicillin		Seafoods		Other _____			
Codeine		Latex		Ibuprofen			

HEIGHT ____feet _____inches WEIGHT _____ lbs

Office use:
Pulse Oximetry _____%

Name _____ **File Number** _____

If Minor, Name of Parent/Guardian _____

Address (Street) _____ **Apt. #** _____

City _____ **State** _____ **Zip** _____

Consent for Treatment:

I certify that the above and attached information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary to the diagnosis and/or treatment of me or my child's condition. As a representative of myself or as a guardian, I give authorization for the above listed patient to receive medical and/or surgical care and treatment with any of the Associated Podiatrists, P.C.

Printed Patients Name: _____

Patient's Signature _____ **Date** _____

Reviewed By: _____ **DPM**