DAVID H. KORFIN, D.P.M., F.A.C.F.A.S.
PODIATRIST – FOOT SPECIALIST

PATIENT INFORMATION

Name:_____Date: _____

Address: _____Apt # _____City/State/Zip: _____

Date of Birth:_____ Age:_____ SS#_____-_____-_____Male_____Female_____Race/Ethnicity_____

Phone: _____Wk Phone: _____ Cell Phone #_____ DL#: _____

Employer: _____Occupation: _____Email: _____

Have you ever had a different name, maiden name?_____ Single___Married___Divorced___Widowed___

POLICY HOLDER INFOFMATION (if different from above)

___Parent ___Spouse ___Self (if self, go to insurance section) Parent or Spouse's Name: _____

Date of Birth: _____ SS#: _____ Occupation: _____

Employer: _____ Wk Phone: _____

EMERGENCY CONTACT (other than spouse)

Name:_____Relationship to you:_____

Street Address: _____Phone: _____

City/State/Zip :_____

Please read and sign below: I directly assign all medical and surgical benefits to the doctor. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that fees for service are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co-insurance. *It is the policy of this office to bill your insurance for reimbursement. However, we shall allow no more than sixty (60) days for payment. After sixty (60) days you will be billed for any outstanding balance on your account. All outstanding balances are due thirty (30) days from the statement date.* I herby authorize Group Medical and Surgical Service to furnish to: Dr. David H. Korfin, who is my physician, any information obtained in the adjudication of any claims in regard to serviced furnished to me under the TITLE XVIII of the SOCIAL SECURTIY ACT.

I HEREBY GIVE AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL RECORDS.

SIGNED:_____DATE:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I knowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name/Signature (please print) Date

_____

Parent or Authorized Representative

****

As your physician, I believe that you are entitled to make informed decisions regarding your medical care. To assist you in making an informed decision, I provide this notification that I hold an ownership interest in:

Hospital of Surgical Excellence of Oak Bend
Elite Center for Minimally Invasive Surgery of Oak Bend
Compound RX
Premier Physical Therapy
National Interventional Radiology Partners

By my signature below, I hereby acknowledge that I have received notification of Dr. Korfin's ownership interests.

Patient Signature _____

ALL INFORMATION MUST FILL OUT ENTIRLY

MEDICAL INFORMATION

This information is important for our records and your health

Patients Name: **_____**

Describe your foot problem: _____

_____

Name of pharmacy: **_____** ***Phone:*** **_____**

Shoe Size _____Current Weight _____Height_____

Are you allergic or sensitive to any of the following:

- Antibiotics (Penicillin, Sulfa drugs, etc.?) _____
- Tape? _____Betadine (iodine)?_____Other: _____
- Have you had problems taking aspirin or ibuprofen (Advil, Motrin)?_____
- Any problems with local anesthetics (Novacaine, Lidocaine)? Yes _____ No _____

GENERAL HEALTH INFORMATION

Do you have any or have you had any of the following?

O None O Diabetes O Heart Disease O High blood Pressure O Gout O Liver
O Asthma O Arthritis O Tuberculosis O Circulation O Cholesterol
O Kidneys O Anemia O Healing O Lungs O Cancer O Intestines problems
O Stroke O Bleeding disorder O Artificial Joints O Thyroid Disease O Bladder Problem
O Rheumatic fever O Mitral valve prolapsed O Skin Problems O Stomach Ulcers
O Frequent Infections O Neurological disorders O Other _____

Please list major surgeries: _____

Physician Name: _____Last visit _____Phone:_____

Are you under a physician's care? Yes_____ No_____
If yes, for what condition?_____

What medications do you take regularly:

_____dosage_____ _____dosage___ _____dosage____
_____dosage_____ _____dosage___ _____dosage____
_____dosage_____ _____dosage___ _____dosage____
_____dosage_____ _____dosage___ _____dosage____

Mother Living__ ___Deceased_____Cause of death_____
Father Living__ ___Deceased_____Cause of death_____
Brother Living__ ___Deceased_____Cause of death_____
Sister Living__ ___Deceased_____Cause of death_____

Is there a family (blood relative) history of:

() Heart Disease Who: _____
() Arthritis () Hypertension () Bunions () Neurological Disorder
() Bleeding Disorder () Asthma () Cancer () Hammer-toes () Flat Feet () Stroke
() Diabetes () Gout () Phlebitis () Circulation problems in legs or feet

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Patients Name: _____

General/Constitutional

Weight gain	O Yes	O No
Weakness	O Yes	O No
Fever	O Yes	O No
Fatigue	O Yes	O No
Weight loss	O Yes	O No

Cardiovascular

Chest pain	O Yes	O No
Leg edema	O Yes	O No
Palpitations	O Yes	O No
Irregular heart beat	O Yes	O No

Gastrointestinal

Diarrhea	O Yes	O No
Vomiting	O Yes	O No
Nausea	O Yes	O No
Reflux	O Yes	O No
Constipation	O Yes	O No

Musculoskeletal

Joint pain	O Yes	O No
Joint swelling	O Yes	O No
Joint stiffness	O Yes	O No
Muscle aches	O Yes	O No

Neurologic

In coordination	O Yes	O No
Gait abnormality	O Yes	O No
Dizziness	O Yes	O No
Tingling/numbness	O Yes	O No

Respiratory

Cough	O Yes	O No
Shortness of breath	O Yes	O No

History of asthma/chronic obstructive pulmonary disease (COPD) O Yes O No

Do you smoke: Yes _____ # of packs per day _____ No _____
Previously smoked? Yes _____ # of years _____ No _____
Do you drink alcohol or beer? Yes _____ No _____ Light __ Moderate __ Heavy ___(2 or more per day)
Do you use recreational drugs? Yes _____ No _ ____
Employment: ( ) Sit ( ) Stand ( ) Stand and walk ( ) Retired
Does the employer require any particular type of shoes? Boots ___ Heels ___ Other ___