Frederick E. Quirante, D.P.M.

HISTORY & PHYSICAL

Name: _____ Date: _____ DOB: _____ Age: _____

Address: _____ Zip Code: _____Marital Status: S M W D

Phone # (cell or home) _____ (Email) _____ Primary Doctor: _____

Weight: _____ Height: _____ Race: _____ Sex: _____ Shoe Size: _____ Social Security # _____

CHIEF COMPLAINT:

_____

_____

_____

_____

PAST MEDICAL HISTORY:

___CHARCOT FOOT / ___FOOT ULCERS (WHERE:_____)
___ DIABETES TYPE 1 OR 2 (A1C _____)
___ HIGH BLOOD PRESSURE
___ CANCER
___ HEART DISEASE (___CONGESTIVE HEART FAILURE ___HEART ATTACK)
___ NEUROPATHY
___ LIVER DISEASE (___HEPATITIS A B C, ___CIRRHOSIS)
___ KIDNEY DISEASE (___ DIALYSIS/END STAGE RENAL DISEASE)
___ ANEMIA ___ AUTOIMMUNE (___SLE ___ RA ____AIDS)
___ ARTHRITIS (___RA ___OSTEO ____GOUT)
___ GASTROESOPHAGEAL DISEASE (GERD / ACID REFLUX DISEASE)
___ LUNG DISEASE (___COPD ___ASTHMA ___ BRONCHITIS ___PNEUMONIA ___TB ___EMPHYSEMA)
___ AUTISM
___OTHER _____

HOSPITALIZATION: _____ **SURGERIES:** _____

_____ _____

_____ _____

TOBACCO: ___+ ½ PACK A DAY ___ - ½ PACK A DAY ___1 PACK A DAY ___2 PACKS A DAY ___NEVER ____ EX-SMOKER

ALCOHOL: ___NEVER ___SOCIAL DRINKER ___DAILY ___RARELY ___OTHER

PHARMACY: _____ (PLEASE INCLUDE LOCATION)

ALLERGIES: (INDICATE TYPE OF REACTION) ❑ NKDA (no known drug allergies)

___ PENICILLIN _____ ___ TAPES\ADHESIVES _____

___ NOVOCAIN\LOCAL ANESTHETICS _____ ___ IODINE _____

___ ASPIRIN _____ ___ SULFA _____

___ CODEINE _____ ___ OTHER _____

HOW DID YOU HEAR ABOUT US: ___DR. REFERRAL ___FAMILY/FRIEND ___WEBSITE ___SOCIAL MEDIA ___PHONE BOOK

*****PLEASE BRING YOUR INSURANCE CARDS & DRIVER'S LICENSE TO THE DESK TO BE SCANNED*****

Name: _____ Date: _____ DOB: _____ Age: _____

MEDICATIONS: ❑ NOT TAKING ANY MEDICATIONS

NAME OF MEDICATION DOSE/DOSAGE REASON HOW LONG? PRESCRIBING DOCTOR

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

FAMILY HISTORY:

Does your Mother, Father, Sister, Brother, Maternal Grandmother or Maternal Grandfather, Paternal Grandmother or Paternal Grandfather have any of the following:

	FAMILY MEDICAL HISTORY	RELATIONSHIP
	ARTHRITIS	
	DIABETES	
	HYPERTENSION	
	CANCER	
	GERD	
	HEART DISEASE	
	HYPERCHOLESTEROLEMIA	
	KIDNEY DISEASE	
	NEUROPATHY	
	STROKE	
	BLOOD CLOTS	
	GOUT	
	HEREDITARY LYMPHEDEMA	
	MULTIPLE SCLEROSIS	
	OTHER	

PATIENTS GIVE PRIMARY CARE PHYSICIAN NAME & DATE LAST SEEN. . .

PCP Name: _____ Date last Seen: _____

Acknowledgment of Receipt of Privacy Practices

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (print): _____

× Patient Signature: _____ Date: _____

Guardian/POA (print):_____ Relationship to Patient: _____

Signature: _____ Date: _____

× Listed below are the Name(s) & Phone Numbers with permission to make appointments, get test results and take care of bills and emergency contact:

Name	Relationship	Phone Number

If at any time there are changes to the above, it must be in writing.

× May we leave the results, appointment, or a message on your answering machine? _____
Yes / No

Office Policies & Disclosures

We require a 24-hour cancellation notice for appointments. If you no-show your appointment without proper cancellation, you will be charged at $20 fee. Excessive missed appointments and no-shows reserves the physician the right to terminate your care.

Frederick E. Quirante, DPM has an interest in CrysonCare Pharmacy and NIRP (National Interventional Radiology Partners) – Beaumont.

I hereby assign my insurance benefits to be paid directly to Frederick E Quirante, DPM. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Frederick E Quirante, DPM to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

× Signature: _____ Date: _____