BRIAN K. DOERR, DPM, PA

Diplomate, American Board of Podiatric Surgery • Certified in Foot and Ankle Surgery

PATIENT REGISTRATION TODAYS DATE_______________

PLEASE FILL OUT COMPLETELY

Patients full name:
Last_____________________ First______________________ MI________ Sex M F

Patient SS #________________________ Date of Birth_______________ Age______

Marital Status S M D W Name of Spouse ________________________________

E-Mail Address ____

Home Phone____________________ Cell____________________________

Local Address____

City________________ State_________ Zip_________

Local Pharmacy_________________ Pharmacy # ______________________

Second or out of state address____________________________________

City______________ State___________ Zip_________ Phone#_______________

Dates at out of state address ____________________ to____________________

Employer Name _______________________ Employer Phone_________________

Occupation____

Whom should we contact in case of emergency ______________________________

Relationship to Emergency Contact ________________________________

Phone number of Emergency Contact ________________________________

How did you hear about us?_______________ If referred, by whom?________________

Name of Family Physician______________________ Date last seen: ______________

Phone___________________________ Fax________________________________

Address____

Who is your Primary Insurance Carrier _______________________________

Who is your Secondary Insurance Carrier ______________________________

Are you the primary card holder? YES or NO

IF NO please provide name primary card holder ___________________________

Date of Birth of primary card holder_________________________________

SS # of primary card holder or parent/guardian ___________________________

14391 Metropolis Ave • Suite 103 • Ft Myers, FL 33912 • Phone: (239) 931-3668 (FOOT) • Fax: (239) 333-3669 • www.docdoerr.com

Consent for Examination and Treatment:

I hereby request and give permission to Dr. Brian K. Doerr and whomever he may designate as his assistants to administer treatment, and to perform such general procedures as he may deem to be necessary in the diagnosis and/or treatment of my foot complaints.

Authorization for Release of Information:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or other insurance carriers or to the billing agent of Brian K. Doerr, DPM any information needed for this and or a related Medicare/Insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Brian K. Doerr, DPM or the party who accepts assignment.

Financial Responsibility:

I agree to be financially responsible for any deductibles, co-insurance and/or co-payments at time of service unless prior arrangements have been made. I also guarantee the payment for any denied or uncovered claims which may be due to Brian K. Doerr, DPM for professional services rendered to me on my behalf. I agree that in the event that my account has to be turned over to a Collection Agency, a collection-fee in the amount of 30% of the then outstanding balance will be added to my account and shall become a part of the Total Amount Due. Any checks returned for non-sufficient funds will result in an additional $25 charge per item added to the account balance, which I agree to pay in full.

Referrals and Authorizations:

If your insurance has designated a primary care physician (PCP), you may be required to have prior authorization from your PCP prior to your office visit with Dr. Brian K. Doerr. If authorization is required and not provided, you will be asked to either reschedule your appointment or pay for the visit in full at the time of service.

Consent to ePrescribe

ePrescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. Congress had determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. It greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act listed standards that have to be included in an ePrescribe program. These include:

- Formulary and benefit transactions - Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions – Provide the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.

By signing this consent form you are agreeing that Dr. Brian K. Doerr can request and use your prescription medication history from the other healthcare providers and or/third party pharmacy benefit payers for treatment purposes.

Understanding all the above, I hereby provide informed consent to Dr. Brian K. Doerr to enroll me in the ePrescribe program. I have had the chance to ask questions and all my questions have been answered to my satisfaction.

I give my consent to Brian K. Doerr, DPM including his medical/office staff to access, use and disclose my protected health information for my treatment, for payment for my treatment and for health care operations consistent with the federal HIPAA privacy act. I consent to the disclosure of my prescription medical information by any provider, pharmacy, and insurer or prescription benefits manager, specifically including any state or federal health benefits program to Brian K. Doerr, DPM for the purpose of my treatment. I am aware that the privacy practices of Brian K. Doerr, DPM are described in its Notice of Privacy Practices. This consent is subject to my revocation at any time except to the extent it has already been acted on.

Print patient's name ____

Patient's or Guardian's Signature________________________________

Relationship to patient (Print) __________________________________

Date____________________

BRIAN K. DOERR, DPM, PA

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PATIENT NAME____________________________________

TODAYS DATE______________**PATIENT REGISTRATION**____________________

Please describe your medical problem / what brings you to the office today?

____

____

How would you describe your pain?
sharp aching throbbing burning cramping
shooting electrical sensation pins and needles numbness

Location of pain or primary complaint:
lower leg ankle achilles tendon heel midfoot arch forefoot
sole of foot ball of foot top of foot big toe lesser toes toenails
Other ____

How long has your problem been present?
1 – 3 days 3 – 7 days 1 – 3 weeks 3 – 6 weeks 6 – 8 weeks
3 – 6 months 6 – 9 months 9 – 12 months greater than 1 year

Onset of condition or injury:
gradual onset over time sudden onset from activity or injury

Course/progression of condition:
severe worsening moderate worsening mild worsening steady/unchanging
mild improvement moderate improvement considerable/good improvement

Have you attempted any treatments to relieve your problem?
rest ice elevation change shoe gear over the counter padding
in home whirlpool stretching trimming out toenail yourself applying skin cream
over the counter anti-inflammatory medication (Motrin, Aleve, Tylenol, Aspirin, etc)
applying topical antibiotic ointment (triple antibiotic, bacitracin, Neosporin)
saw another physician for this problem - instructed to be seen in this office
treated for this condition by another physician
surgery for this condition by another physician

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Pain/condition aggravated by:
any weight bearing standing walking running exercise bending stooping
pressure on ball of foot pressure from shoes pressure from jumping
rubbing from clothing

Additional factors that aggravate the pain:
pain worse first thing in the morning when walking/activity pain worse in shoes
pain worse when standing and walking after rest pain worse with any movement
pain worse after running/ exercise pain worse after working on ladder
pain decreases after 1st 15- 20 minutes of walking pain decreases after rest
pain decreases after removing shoes pain decreases after rubbing area
pain decreases after trimming out toenail, but returns in several days

How much improvement and relief have you achieved with previous treatments?
mild improvement moderate improvement considerable improvement
no improvement worsening of condition

What is your activity level at work :
sitting standing walking considerable movement/walking retired

How did you hear about our office?
Physician family/friend internet newspaper phone book advertisement

Past medical history:
hypertention/high blood pressure HIV/AIDS hepatitis heart attack/MI
insulin dependent diabetes non insulin dependent diabetes pre diabetic
blood clot stroke/CVA aneurysm

Do you have:
fatigue nausea chills
weight gain greater than 10 pounds weight loss greater than 10 pounds

Eyes - Do you have:
impaired vision cataracts glaucoma
macular degeneration frequent eye infections

Ears - Do you have:
hearing loss frequent ear infections
dizziness loss of balance

Nose - Do you have:
sinus problems/allergies frequent nose bleeds difficulty breathing
nasal polyps deviated septum
Medications for the above condition ________________________________

Throat - Do you have:

frequent throat infections hoarseness
difficulties with speech frequent swollen nodes/glands in neck

Medications for the above condition ______________________

Respiratory - Do you have:

asthma bronchitis emphysema shortness of breath tuberculosis valley fever
lung cancer collapsed lung/atelectasis pneumonia

Medications for the above condition ______________________

Cardiovascular - Do you have:

hypertension/high blood pressure myocardial infarct/heart attack chest pain
angina palpitations/irregular beats valve prolapse/heart murmur rheumatic fever
angioplasty open heart/bypass surgery pacemaker congestive heart failure

Medications for the above condition ______________________

Vascular/Circulation - Do you have?

circulation disorder/decrease leg pain at rest leg pain with walking
atherosclerosis/blocked arteries high cholesterol phlebitis
blood clot/deep vein thrombosis varicose veins

Medications for the above condition ______________________

Gastrointestinal - Do you have:

reflux/heart burn ulcer abdominal pain gallbladder problems liver disorder
hepatitis A hepatitis B hepatitis C excessive hunger excessive thirst
loss of appetite colitis

Medications for the above condition ______________________

Genitourinary - Do you have:

frequent bladder/urinary tract infections kidney stone frequent urination/incontinence
renal failure renal dialysis Ovarian cancer (female only) Prostate cancer (male only)
prostrate problems/benign prostatic hyperplasia (male only)

Medications for the above condition ______________________

Genitourinary - Have you had any of the following Sexually Transmitted Diseases?

gonorrhea syphilis chlamydia herpes HIV

Medications for the above condition ______________________

Hematologic -Do you have:

anemia sickle cell disease or trait cancer/leukemia blood tranfusion

Hematologic - Have you been anticoagulant with any of the following blood thinners?

coumadin heparin aspirin plavix other blood thinners/ anticoagulant medications

Endocrine - Do you have:
Diabetes Thyroid disease
Medications for the above condition ______________________________

Neurological - Do you have:
seizures stroke tremor change in memory frequent head aches polio
muscle weakness neuro-muscular disease numbness sciatica
Medications for the above condition ______________________________

Musculoskeletal - Do you have:
arthritis/degenerative joint disease rheumatoid arthritis gout back pain
hip pain knee pain frequent muscle/tendon/pain fibromyalgia
Medications for the above condition ______________________________

Musculoskeletal - Do you have any of the following joint replacements/prosthesis:
hip knee ankle
hands feet spine
Date of joint replacement: ______________________

Integument - Do you have:
skin rashes psoriasis eczema skin cancer hives skin growth
color change to mole or wart change in size of skin growth itching to skin
thick scar/keloid
Medications for the above condition ______________________________

Psychiatric - Do you have:
depression nervousness anxious/OCD phobias bipolar disease memory loss
concentration difficulties/ADHD feelings of worthlessness/low self esteem
suicidal schizophrenia/psychosis
Medications for the above condition ______________________________

Immunology - Do you have:
HIV Frequent infections/weak immune system chronic fatigue syndrome/Ebstein Barr
Medications for the above condition ______________________________

Past Foot Surgeries: Have you had any of the following surgeries?
toenail bunion hammertoe fracture repair joint fusions
tendon repair/rerouting ankle stabilization arthroscopy fasciotomy

Please list approximate month **AND** year of any surgery listed above:
____

Past Surgical History: Have you had any of the following surgeries?
heart bypass heart valve repair/replacement appendectomy
gallbladder brain surgery other
Please list approximate month **AND** year of any surgery listed above:

____

Any other surgeries/injuries/traumas? (Please specify type of surgery and date)

____

Any complications/problems with surgery or anesthetics? (please specify)

____

Previous hospitalization - have you been admitted for:
heart attack stroke pneumonia cancer
infection injury other hospitalizations
Please list approximate month and year of any hospitalization listed above:

____

Childhood History – Have you ever had:
rheumatic fever measles mumps chickenpox herpes/cold sores

Childhood Immunizations – have you been immunized for:
measles mumps rubella diphtheria tetanus varicella zoster
polio tuberculosis pneumonia pertussis flu

Family History - Father - Does/Did your father have:
hypertension/high blood pressure CVA/stroke diabetes
cancer circulation problems
Any other illnesses? (please list)

____

Is your father deceased? yes no
If your father is deceased - age and cause of death_______________________

Family History - Mother - Does/did your Mother have:
hypertension/high blood pressure CVA/stroke diabetes
cancer circulation problems
Any other illnesses? (please list)

____

Is your mother deceased? yes no
If your mother is deceased - age and cause of death_______________________

Family History Siblings - Does/Did your siblings have:
hypertension/high blood pressure CVA/stroke diabetes
cancer circulation problems
Any other illnesses? (please list)

____

Social History - Do you:
smoke tobacco smoke marijuana use hallucinogenic drugs
drink alcohol use cocaine use other recreational drugs
If you use other recreational drugs - please list/specify:

____

Number of drinks per day?
1 2 3 4 5 greater than 5 per day 1-3/week 4-6/week
Occasional use only social drinking only weekend drinking only

Smoking Status
Never smoked Current everyday smoker Social smoker Unknown if ever smoked

If you smoke, number of packs per day?
1/2 1 2 3 4 5 or more
1-2/week 3-4/week Occasional social weekends

Former smoker
Please specify how long since you stopped smoking **AND** how many years you smoked

Stopped smoking less than 6 months ago
Stopped smoking 6 to 12 months ago
Stopped smoking 1 to 2 years ago
Stopped smoking 2 to 5 years ago
Stopped smoking greater than 5 years ago

Smoked for less than 5 years
Smoked for 5 to 10 years
Smoked for 10 to 15 years
Smoked for 15 to 20 years
Smoked for greater than 20 years

Women - Are you pregnant?
yes no
If pregnant, number of months: ______________________

Education:
did not complete high school completed high school some college
completed college some grad school masters degree doctorate degree

Medications - please list any medications not listed above (including aspirin) currently taking: ____

____

____

Allergies - Do you have allergies to any of the following:

drug allergies	penicillin	sulfa	erythromycin
aspirin	cortisone	codeine	adhesive tape
local anesthetics	iodine	latex	***no known allergies***

Please list severity **AND** type of allergic response:
mild moderate severe skin rash itching hives GI upset nausea/vomiting
diarrhea wheezing respiratory distress rapid pulse heart palpitations anaphylaxis

____

Do you have any allergies to **plants** – is so, please list:

____

Do you have any **food** allergies - if so, please list:

____

What is your height? ______________ What is your weight? ______________ Shoe size? ______________