

Dunnellon Podiatry Center, P.A.

Dr Stacy L Witfill, DPM

11786 Cedar Street
Dunnellon, FL 34431

(352) - 489 - 6621

We are Fragrant Free!

Please bring a photo ID, your insurance cards and a medication list when you come to your appointment

Patient Information

First name

Middle Initial

Last name

Date of birth

Occupation

Social Security Number

Employer Phone Number

Gender

Race

Marital Status

Preferred Pharmacy

Height

Weight

Contact Information

Phone Number

Cell Phone Number

Email address

Street Address

Apartment, Suite, etc.

City

State

Zip

Can we contact you by phone, email and voicemail Yes/No - If no, what is your preferred method of communication?

Insurance Information

If you have a secondary plan or supplement, select add new row and provide that information as well.

1

Provider

Policy/Group Number or Member ID

Relationship to Insured

Emergency Contact

1

First name

Last name

Phone number

Relationship

Name of Primary Care Physician

Referral Source

How did you hear about us?

List Of Medications. Please include name and dosage

-
-
-
-
-
-
-

Check Any Allergies That May Apply To You

None Penicillin Sulfa Iodine Tetanus Lidocaine other

If Other Allergies Please Specify Here

Check Your Response - Do You Live With

Alone Spouse Family Friend Other

Smoking Status

Current Light Heavy Never Former Unknown

Alcohol Use

Never Daily Weekly Occasionally Rare

Use of Illegal Drugs

Yes No

Check if you had any of the following

Bruise Easily Paralysis

- Psoriasis
- Toenail Problems
- Difficulty Walking
- Dermatitis
- Tingling
- Weakness
- Non-Healing Wounds
- Skin Cancer
- Balance Problems
- Tremors
- Abnormal Bleeding
- Athletes Foot
- Numbness
- Eczema
- Hives
- Uncontrolled Movements
- Excise Scar Tissue After Cut of Surgery

Patient History

- Acne
- Attention Deficit Disorder
- Allergies
- Angina
- Anemia
- Anxiety
- Anxiety-Depression Disorder
- Arthritis-Degenerative
- Arthritis Rheumatoid
- Asthma
- Atrial Fibrillation
- Back Pain
- Basal Cell Cancer
- Benign Prostatic
- Barrett's Esophagus
- Bi-Polar Disorder
- Cancer
- Congestive Heart Failure
- Carpal Tunnel Syndrome
- Chronic Pain Syndrome
- Chronic Sinusitis
- Coronary Artery Disease
- COPD
- Crohn's Disease
- CVA (Stroke)
- Depression
- Diverticulitis
- Diabetes
- Eczema
- Endometriosis
- Esophageal Efflux
- Fibromyalgia
- Fibroids
- Gout
- Genital Herpes
- Hep C
- Hemorrhoids
- Gastroesophageal Reflux
- Hypertension (High Blood Pressure)
- Hypothyroidism
- Irritable Bowel Syndrome
- Insomnia
- Kidney Disease
- Kidney Stones
- Lung Disease
- Abnormal Liver Test
- Migraines
- Mitral Valve Prolapse
- Obesity
- Obesity
- Obstructive Sleep Apnea
- Osteopenia
- Peptic Ulcer Disease
- Peripheral Vascular Disease
- Polycystic Ovarian Syndrome
- Restless leg syndrome

- | | | |
|---|--|---|
| <input type="checkbox"/> Cardiac (Heart) Murmur | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Squamous Cell Cancer |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> In Remission-Drug Dependency | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> Hyperlipidemia (High Cholesterol) | <input type="checkbox"/> Ulcerative Colitis |
| | | <input type="checkbox"/> NEUROPATHY |
| | | <input type="checkbox"/> HEP B |

Past Surgical Procedures

- | | | |
|--|---|--|
| <input type="checkbox"/> Abdominoplasty (Tummy Tuck) | <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Lumpectomy |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Cesarean Section | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Ankle Surgery | <input type="checkbox"/> Cholecystectomy (Gall Bladder) | <input type="checkbox"/> Nasal Septum |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Foot Surgery | <input type="checkbox"/> Rhinoplasty |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hand Surgery | <input type="checkbox"/> Shoulder Surgery |
| <input type="checkbox"/> Breast Biopsy | <input type="checkbox"/> Hernia Surgery | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Splenectomy |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Spinal |
| <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> Knee Surgery | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> CABG (Heart Bypass) | <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> Tonsillectomy/Adenoidectomy |
| <input type="checkbox"/> Cardiac Catheterization | <input type="checkbox"/> Lasik Surgery | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Carpal Tunnel | | |

Family History - Indicate if Mother, Father, Brother, Sister, Maternal/Paternal Grandparents

Diabetes

Arthritis

Stroke

Cancer

Heart Attack

Foot Problems

High Blood Pressure

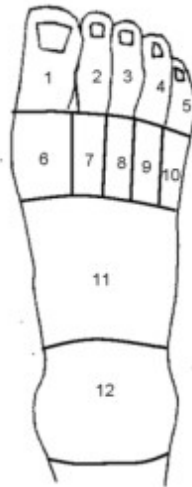
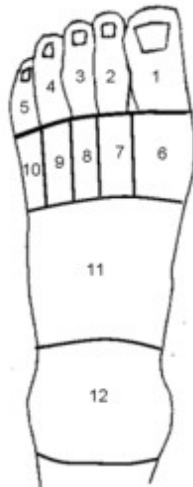
Coronary Artery Disease

Other Family History

Mark the areas on the image where you are experiencing symptoms

Left foot

Right foot



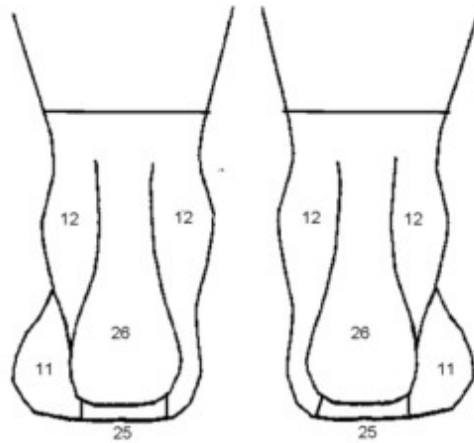
Sole / bottom

Top

Top

Sole / bottom

Ankles (back view)



Left

Right

Please select one area per complaint and fill out the corresponding questions. If the complaint is widespread or radiating to other areas of foot/ankle, select only the area on foot of main concern and leave note of the other issues it's causing.

Describe Your Pain

- Aching
- Burning
- Constant
- Cramping
- Disabling
- Excruciating
- Intermittent/Inconsistent
- Pressure
- Radiating/Shooting
- Tender
- Worse In Morning
- Worse at Night
- Feels Like Walking on Rock or Pebble
- Tolerable

Severity of Pain

Was This An Injury or A Trauma?

When Did The Problem Start?

Any other details about the issue that you feel is important?

Past Treatment Attempts/ Home Care

Any Other Information You Think Is Helpful

Patient Consent

1. I hereby consent to examination and treatment as deem necessary by Dunnellon Podiatry Center, Stacy L Witfill,DPM. I hereby authorize Dunnellon Podiatry Center to furnish Patient Health Information concerning my relevant medical history to any of the following other Healthcare providers involved in my care, insurance carriers, attorneys and adjustors. I herby consent to the use of a patient portal, surveys, automated telephonic and email appointment reminders. I hereby assign to Dunnellon Podiatry Center all payments for medical services rendered to myself or my dependents understand that I am responsible for any amounts not covered by insurance. I acknowledge that to the best of my knowledge the information in this form is accurate and complete.
2. In accordance with the Health insurance Portability and Accountability Act patients of DPC are entitled to and afforded the rights to privacy regarding their health related information as set forth under applicable law. A patient's protected health information (PHI) may only be released as authorized by his law. DPC will strive to ensure that PHI is used only for purposes

authorized by the patient including but not limited to patient treatment, payment options, lawful subpoenas and as other wise required by law. Upon request we can provide you with a complete copy of our privacy policies. Additionally upon providing reasonable advance notice patients have the right to review their medical records during normal business hours. In addition patients have the right to obtain information regarding entities to which PHI has been provided. Patients have the right to be informed of any breach of their unprotected PHI. To have marketing communications made to them only if authorized by patient. To decline to have PHI delivered to health insurers if the patient pays for services in full with out filling a claim.

3. Medicare patients - I hereby certify that the information given to me in applying fir payment under title XVIII of social security act is correct. I hereby authorize any holder of medical or other information about me to be released to social security administration or its intermediaries or carriers any information needed for this or related Medicare claim. I hereby request that payment of authorized benefits be made on my behalf and hereby assign the benefits payable for physician services to the physician if he/she chooses to accept assignment.
4. Consent for transfer of biological specimen. Florida law (section 817.5655 FI statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party with out express consent of such person. During the course of your care at Dunnellon Podiatry Center (DPC) it maybe medically necessary to obtain a blood, urine, stool tissue or other types of biological specimen for analysis. This analysis will not involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed it will be stored as medical waist and then transferred to a third party for disposal in accordance with all local state and federal requirements. It may also be the case that a biological specimen (blood, urine, hair, bodily fluids, ect) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal. By signing this document you affirmatively state that it is intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with DPC to a third party as set forth above. This consent does not authorize the sale or transfer of any biological specimen for the purpose of DNA analysis.
5. Patients release - I hereby authorize DPC to release any or all of my PHI including super confidential information, billing and insurance inquires to the persons listed below (spouse, relative, friend, ect)

Signature

Date

Please be sure to bring a photo ID and your insurance cards with you to your appointment.