WELCOME TO THE OFFICE OF

DR. DAVID W. GOOCH, D.P.M.

DATE _____

PATIENT'S NAME _____

DATE OF BIRTH _____SOCIAL SECURITY #_____

ADDRESS_____

CITY_____ STATE_____ ZIP _____

E-MAIL ADDRESS_____@_____

Our office provides the service of "reminder calls". To protect your privacy, please indicate how you would prefer this to be done.

Cell Number:_____ Leave Message? (circle one) Yes No

Automated Text reminders? (circle one) Yes No

Home Number: _____ Leave Message? (circle one) Yes No

Work Number: _____ Leave Message? (circle one) Yes No

PHARMACY _____ CROSS STREETS_____ZIP CODE_____

SEX: MALE FEMALE

( ) WHITE ( )HISPANIC/LATINO ( )ASIAN ( ) AFRICAN AMERICAN

( ) AMERICAN INDIAN ( ) PACIFIC ISLANDER

OCCUPATION EMPLOYER _____

SPOUSE'S NAME _____ DATE OF BIRTH _____

SPOUSE'S EMPLOYER PHONE _____

EMERGENCY CONTACT PERSON_____

CONTACT PERSON PHONE _____ RELATIONSHIP _____

WHO REFERRED YOU TO OUR OFFICE? _____

HAVE YOU SEEN A PODIATRIST BEFORE? YES NO

IF YES, DOCTOR'S NAME _____ LAST VISIT_____

PRIMARY DOCTOR'S NAME _____ PHONE _____

ARE YOU CURRENTLY UNDER THE CARE OF A DOCTOR OR SPECIALIST? YES NO

IF YES, PLEASE EXPLAIN _____

PRESENT COMPLAINT YOU ARE HAVING WITH FOOT/ANKLE?

_____

HEIGHT _____ WEIGHT _____ SHOE SIZE_____

ATHLETIC ACTIVITIES IN WHICH YOU PARTICIPATE AND FREQUENCY

_____

DO YOU HAVE A FAMILY HISTORY OF DIABETES? YES NO

DO YOU SMOKE? YES NO PACKS PER DAY_____ #OF YEARS _____

SMOKED PREVIOUSLY? YES NO PACKS PER DAY _____ #OF YEARS_____

DO YOU DRINK ALCOHOL? YES NO AMOUNT_____

DO YOU HAVE ANY OF THE FOLLOWING?

AIDS/HIV_____	ANEMIA_____	ARTHRITIS_____
ASTHMA_____	BACK PAIN_____	BLEEDING TENDENCIES_____
CANCER_____	EPILEPSY_____	CIRCULATORY PROBLEMS___
DIABETES_____	HEPATITIS_____	CHEMICAL DEPENDENCY____
STROKE_____	TUMORS_____	HIGH BLOOD PRESSURE____
ULCERS_____	HEART DISEASE_____	NERVOUSNESS_____
KIDNEY TROUBLE_____	PHLEBITIS_____	RESPIRATORY DISEASE_____
NEUROPATHY_____	TUBERCULOSIS_____	LIVER DISEASE_____
GOUT_____	VARICOSE VEINS_____	OTHER_____

FAMILY HISTORY:

Please indicate if a family member has/ had any of the following by specifying the family member and type.

Diabetes ☐ Mother ☐ Father ☐ Brother ☐ Sister

Heart Disease ☐ Mother ☐ Father ☐ Brother ☐ Sister Type: _____

Cancer ☐ Mother ☐ Father ☐ Brother ☐ Sister Type:_____

Kidney Disease ☐ Mother ☐ Father ☐ Brother ☐ Sister

High Blood Pressure ☐ Mother ☐ Father ☐ Brother ☐ Sister

MEDICATIONS	DOSAGES / FREQUENCY

SEE ATTACHED LIST OF MEDICATIONS I BROUGHT TO MY VISIT TODAY ☐

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ Yes ☐ No. If yes, please list below:

☐ Aspirin ☐ Codeine ☐ Iodine ☐ Penicillin ☐ Sulfa ☐ Others_____

Type of Reaction_____

IMMUNIZATION:

Pneumovax (pneumonia vaccine) Date: _____

Influenza (Flu Shot) (date of last shot) Date: _____

Date of Last Covid-19 Vaccine: _____

RECENT SURGERIES OR HOSPITALIZATIONS:

_____

To the best of my knowledge the above information is complete and accurate. I authorize the release of any medical, psychiatric, or other information necessary to process any claim and to provide information to another health care provider when necessary to coordinate treatment. I also authorize payment of benefits to Gooch Foot & Ankle Specialists. I fully understand that if my insurance denies payment for any service defined as "non-covered", I will be responsible for that amount due, including annual deductibles, co-payments, insurance rejections, cash charges, etc. In the event this account must be placed with a collection agency, patient or responsible party agrees to pay all collection costs. I acknowledge that I was provided a copy of the notice of privacy practice and I have/ had the opportunity to read and understand the notice.

PATIENT SIGNATURE_____ DATE _____