Welcome to the Office of
Dr. Steven Hollander DPM

Date _____
Patient's Name _____
Date of Birth _____SSN #_____
Address_____
City_____ State_____ Zip_____
E-mail_____@_____
Cell #: _____ Home #: _____ Work #: _____
Sex : Male Female
Race: White Hispanic/Latino African American/ Black
Asian American Indian Pacific Islander
Occupation/ Employer_____
Emergency Contact Person_____
Contact Person Phone # _____
Name of POA (if applicable) _____
Who Referred you to our office? _____
Primary Doctor's Name: _____
Pharmacy_____ Cross Streets/ Address _____
Zip_____
(If cards not provided) Insurance_____
Secondary Insurance _____
(Tricare patients)
Sponsor Name and their SSN# _____

Patient Insurance Disclosure Contract

I request that payment of authorized Medicare, AHCCCS and/or commercial insurance plans be made to Steven B Hollander DPM LLC for any service(s) rendered to me. I Authorize Dr Steven Hollander to release my medical information as regulated under the Federal HIPPA Privacy Laws.

I understand that I am responsible to pay certain amounts to the physician. These amounts may include annual deductibles, co-pays, co-insurance, charges denied as not covered by my insurance(s), and charges denied for services or items determined as not medically necessary.

I further understand that if Dr Steven Hollander incurs any fees associated with collecting reimbursement on my account I will be responsible for paying those fees. I certify that the information I have provided is accurate to the best of my knowledge and any missing information will be provided within 72 hours of my visit in order for Dr Steven Hollander to bill the insurance(s) on my behalf.

Patient/Guardian Signature	**Printed Name**	**Date**

Patient Name: _____ Date of Birth: ___/___/____

Who is you Primary Care Physician? _____ Phone: _____

How were you referred to our office? _____

Please list ALL medications you are currently taking (Include prescription, over the counter med & herbal supplements):

Name: Dose: Name: Dose:

_____

_____

_____

_____

_____

Please list all Prior Surgeries:

Type of Surgery Date Type of surgery: Date:

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ ***YES*** ☐ ***NO.*** ***If yes, please list below:***

☐ ***Aspirin*** ☐ ***Codeine*** ☐ ***Iodine*** ☐ ***Penicillin*** ☐ ***Sulfa*** ☐ ***Others*** _____

Type of reaction: _____

Have you received the Flu Vaccination? ☐ Yes ☐ No If yes, approx. date given_____

Have you received the Pneumonia Vaccine? ☐ Yes ☐ No If yes, approx. date given_____

Social History:

Marital status: ___ Single ___ Married ___ Partnered ___Separated ___ Divorced ___ Widowed

Use of Alcohol: ___ Never ___ No longer use ___ History of alcohol abuse

Use tobacco: ___ Never ___ Quit-How long ago? _____Smoke ____ Packs/day for ___ years

Use of Recreational Drugs: ___ Never ___ Quit-How long ago? ____ Type: _____

Family History:

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

Diabetes: Father ___ Mother___ Siblings ___ Children ___ Other ___ Type: _____

High Blood Pressure: Father ___ Mother___ Siblings ___ Children ___ Other ___ Type: _____

Heart Disease: Father ___ Mother___ Siblings ___ Children ___ Other ___ Type: _____

Cancer: Father ___ Mother___ Siblings ___ Children ___ Other ___ Type: _____

Kidney Disease: Father ___ Mother___ Siblings ___ Children ___ Other ___ Type: _____

Patient Name _____ Height: _____ Weight: _____ Shoe Size: _____

CHECK ALL THAT APPLY

EYES	CONSTITUTIONAL SYMPTOMS	GU
☐ LIGHT SENSITIVITY ☐ TENDERNESS ☐ VISUAL DISTURBANCE ☐ CATARACTS ☐ EYEGLASSES NONE ☐	☐ FEVER ☐ CHILLS ☐ NAUSEA ☐ VOMITING ☐ SHORTNESS OF BREATH ☐ CHEST PAIN NONE ☐	☐ FREQUENT UTIs ☐ PROSTATE PROBLEMS ☐ GYNECOLOGICAL PROBLEMS ☐ KIDNEY DISEASE NONE ☐
EARS / NOSE / THROAT / HEAD	**CARDIOVASCULAR**	**ENDOCRINE**
☐ RINGING IN EARS ☐ MOUTH PAIN ☐ DIFFICULT SWALLOWING ☐ SORE THROAT ☐ NOSE BLEED ☐ NASAL INFLAMMATION ☐ NECK PAIN / STIFFNESS ☐ HEADACHES ☐ DENTURES ☐ LARYNGITIS NONE ☐	☐ HIGH BLOOD PRESSURE ☐ CHEST PAIN ☐ IRREGULAR HEART BEAT ☐ CONGESTIVE HEART FAILURE ☐ PACEMAKER/DEFIBRILLATOR ☐ BLOOD CLOTS ☐ CORONARY ARTERY DISEASE ☐ VENOUS INSUFFICIENCY ☐ HEART ATTACK ☐ PERIPHERAL ARTERIAL DISEASE NONE ☐	☐ DIABETES ☐ HYPOTHYROIDISM ☐ HYPERTHYROIDISM ☐ CHANGE IN APPETITE ☐ NIGHT SWEATS ☐ EXCESSIVE URINATION NONE ☐ **PYSCHIATRIC** ☐ DEPRESSION ☐ ANXIETY NONE ☐
GASTROINTESTINAL	**HEMATOLOGIC / LYMPHATIC**	**MUSCULOSKELETAL**
☐ ACID REFLUX ☐ DIARRHEA ☐ CONSTIPATION ☐ DIVERTICULOSIS ☐ IRRITABLE BOWEL NONE ☐	☐ LONG TERM ANTICOAGULANT USE ☐ BLEEDING DISORDERS ☐ CLOTTING DISORDER ☐ ANEMIA NONE ☐	☐ ARTHRITIS ☐ LEG CRAMPS ☐ MUSCLE SPASM ☐ STIFFNESS /SWELLING ☐ JOINT PAIN ☐ PRIOR FRACTURES / SPRAINS NONE ☐
RESPIRATORY	**NEUROLOGICAL**	**INTEGUMENTARY**
☐ DIFFICULTY BREATHING ☐ CONGESTION ☐ DYSPNEA ☐ WHEEZING ☐ ASTHMA ☐ COPD / EMPHYSEMA ☐ SLEEP APNEA	☐ DIZZINESS ☐ FAINTING ☐ NUMBNESS / TINGLING / BURNING ☐ WEAKNESS ☐ POOR BALNCE NONE ☐	☐ SKIN ULCERS ☐ SKIN GROWTHS ☐ ABRASION ☐ ITCHY SKIN ☐ LACERATIONS ☐ RASHES NONE ☐