Gooch Foot & Ankle Specialists

Dr. David Gooch DPM *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 # _____Relation:_____

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 _____

(For Tricare patients)

Sponsor Name and their SSN# _____

Height _____ Weight _____ Shoe Size_____
Do you Smoke? YES NO Packs per day_____ Do you Vape? YES NO
Smoked Previously? YES NO #OF YEARS_____
Do you drink alcohol? YES NO AMOUNT_____

FAMILY HISTORY:
Please indicate if a family member has/ had any of the following by specifying the family member and type. Circle all that apply.
Diabetes: Mother Father Brother Sister
Heart Disease: Mother Father Brother Sister
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 Reactions _____
Recent Surgeries or Hospitalizations:

_____

_____

Have you fallen in the past year? _____Do you feel unsteady when standing/ walking?_____
Pneumovax (pneumonia vaccine) Date: _____
Influenza (Flu Shot) (date of last shot) Date: _____

CHECK ALL THAT APPLY

EYES

- ☐ LIGHT SENSITIVITY
- ☐ TENDERNESS
- ☐ VISUAL DISTURBANCE
- ☐ CATARACTS
- ☐ EYEGLASSES

NONE ☐

CONSTITUTIONAL SYMPTOMS

- ☐ FEVER
- ☐ CHILLS
- ☐ NAUSEA
- ☐ VOMITING
- ☐ SHORTNESS OF BREATH
- ☐ CHEST PAIN

NONE ☐

GU

- ☐ FREQUENT UTIs
- ☐ PROSTATE PROBLEMS
- ☐ GYNECOLOGICAL PROBLEMS
- ☐ KIDNEY DISEASE

NONE ☐

EARS / NOSE / THROAT / HEAD

- ☐ RINGING IN EARS
- ☐ MOUTH PAIN
- ☐ DIFFICULT SWALLOWING
- ☐ SORE THROAT
- ☐ NOSE BLEED
- ☐ NASAL INFLAMMATION
- ☐ NECK PAIN / STIFFNESS
- ☐ HEADACHES
- ☐ DENTURES
- ☐ LARYNGITIS

NONE ☐

CARDIOVASCULAR

- ☐ 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 ☐

ENDOCRINE

- ☐ DIABETES
- ☐ HYPOTHYROIDISM
- ☐ HYPERTHYROIDISM
- ☐ CHANGE IN APPETITE
- ☐ KIDNEY DISEASE

NONE ☐

PSYCHIATRIC

- ☐ DEPRESSION
- ☐ ANXIETY

NONE ☐

GASTROINTESTINAL

- ☐ ACID REFLUX
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ DIVERTICULOSIS
- ☐ IRRITABLE BOWEL
- ☐ URINARY INCONTINENCE

NONE ☐

HEMATOLOGIC / LYMPHATIC

- ☐ LONG TERM ANTICOAGULANT USE
- ☐ BLEEDING DISORDERS
- ☐ CLOTTING DISORDER
- ☐ ANEMIA

NONE ☐

- ☐ HIV / AIDS

MUSCULOSKELETAL

- ☐ ARTHRITIS
- ☐ LEG CRAMPS
- ☐ MUSCLE SPASM
- ☐ STIFFNESS /SWELLING
- ☐ JOINT PAIN
- ☐ PRIOR FRACTURES / SPRAINS

NONE ☐

RESPIRATORY

- ☐ DIFFICULTY BREATHING
- ☐ WHEEZING
- ☐ ASTHMA
- ☐ COPD / EMPHYSEMA
- ☐ SLEEP APNEA

NONE ☐

NEUROLOGICAL

- ☐ DIZZINESS
- ☐ FAINTING
- ☐ NUMBNESS / TINGLING / BURNING
- ☐ WEAKNESS
- ☐ POOR BALANCE

NONE ☐

INTEGUMENTARY

- ☐ SKIN ULCERS
- ☐ SKIN GROWTHS
- ☐ ABRASION
- ☐ ITCHY SKIN
- ☐ RASHES

NONE ☐

Financial Agreement and Consent to Treat

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/LEGAL GUARDIAN SIGNATURE_____

DATE _____

Consent to Use Scribe Software powered by Artificial Intelligence during Medical Encounters

We are committed to providing the best possible care for you, and as part of this commitment, we are continually looking for ways to enhance our services. We would like to inform you about a new technology that we are using called AI Scribe which is an artificial intelligence (AI) tool that assists us during patient encounters by generating clinical notes based on our conversations. This tool allows us to focus more on you, the patient, and less on computer documentation. AI Scribe is a tool that listens to the conversation during a medical consultation and generates a written summary or "note" based on that conversation. This note is then reviewed and approved by your doctor. The AI Scribe tool does not interact with you directly. *It merely listens to the conversation and creates a summary.* This can allow the doctor to focus more on the visit and less on taking notes. We want to assure you that your privacy is our utmost priority. The AI Scribe tool adheres strictly to Health Insurance Portability and Accountability Act (HIPAA) compliance guidelines to ensure your data is secured and protected. Only the healthcare professionals involved in your care will have access to these notes and notes are deleted after each visit.

Your participation is completely *voluntary*. If you agree to the use of AI scribe software during your consultations, please sign and date the form below. If you have any questions or concerns, please feel free to discuss them with us. Thank you for your understanding and cooperation.

By signing below, I consent to the use of AI Scribe Software during my medical encounters/appointments.

SIGNATURE _____ **DATE** _____