



FOOT AND ANKLE CENTER, LLC

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Providence Professional Park
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Egg Harbor Township, NJ 08234
(609)272-1450 Fax (609)272-1445

Patient's Name _____ Today's Date _____

Birthdate ___/___/___ Age ___ Male ___ Female ___ Social Security # _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

May we call and leave a message on your answering machine? Yes ___ No ___

Status: Minor ___ Single ___ Married ___ Divorced ___ Separated ___ Widows ___

Spouse's Name: _____

Referred By: _____ Email Address: _____

Employer: _____

Occupation: _____ Work Phone: _____

Primary Language _____

Race: White ___ African American ___ Asian ___ Other _____

Insurance Name: _____

ID# _____ Group# _____

Insured's Name: _____ Social Security# _____

Insured's Employer: _____ Birthdate: ___/___/___

Secondary Insurance: _____

Emergency contact: _____ Relation: _____

Phone: _____ Secondary Phone: _____

Family Doctor: _____ Phone# _____

Pharmacy Name/Phone Number: _____

Reason for visit: _____

Please describe pain and its location: _____

When did condition begin? _____ Is it getting worse? _____

ALLERGIES

- NONE OTHER _____
 Penicillin Sulfa Iodine Aspirin Anesthetics Latex
 Codeine Demerol Darvocet Cortisone Environmental Food

Type of Reactions: _____

MEDICAL HISTORY

- Diabetes Fibromyalgia Tumors Epilepsy Nerve Condition Heart Problems
 Arthritis Gout Asthma/COPD Glaucoma Stomach Ulcers Skin Disorders
 Tuberculosis Anemia Bursitis AIDS (HIV) Lung Disease Kidney Problems
 Sickle Cell Stroke Hepatitis Osteoporosis Bleeding Problems Colitis / Crohn's
 Mental Disorders Poor Circulation High Blood Pressure Joint Implants Thyroid Disease Rheumatic Fever
 Heart Burn /Reflux Sexually Transmitted Disease High Cholesterol Cancer: type _____
 Diabetes; what is the name, phone number, and address of the doctor treating you for diabetes? _____

When was your last visit? ___/___/___ What is your average blood sugar reading? _____
 Are you pregnant? ___Yes ___No How many months? _____

SURGICAL HISTORY

PROCEDURE	DATE	COMPLICATIONS

5) Have you ever had an injury to the lower extremity? ___Yes ___No Explain _____

FAMILY HISTORY

*Please check all that apply

	FATHER	MOTHER	BROTHER	SISTER
Diabetes				
Heart Disease				
High Blood Pressure				
Arthritis				
Gout				
Thyroid				
Cancer (what type)				
Other				

SOCIAL HISTORY

Date of last physical Exam: ___/___/___

Do you smoke tobacco? ___Yes ___No

If Yes: # packs per day? ___ # cigarettes per day? ___ # of years Smoking? ___

If No: Did you ever smoke? ___Yes ___No

If Yes: How long ago did you stop smoking? _____

Do you drink alcohol? ___Yes ___No

If Yes: How much? ___< 1 per week ___1-2 per week ___1-2 per day ___more than 3 per day

Recreational drug use: ___Yes ___No

If Yes: What substance and how often? _____

REVIEW OF SYSTEMS

*If you are experiencing any of the following please **CIRCLE**:

Head: Chronic Headaches, Concussion, Dizziness, Loss of Consciousness

Eyes: Glasses, Contacts, Double Vision, Blurred Vision, Blindness, Cataracts

Ears: Deceased or Loss of Hearing, Ringing in the Ears, Chronic Earaches

Nose: Drainage or Infection, Blockage, Bleeding, Sinusitis

Throat: Chronic Tonsillitis, Laryngitis, Difficulty Swallowing, Loss of Speech

Cardiovascular: Chest pain, Shortness of Breath, Palpitations, Murmurs, Heart Valve Disease, Anemia, Leg Cramps

Respiratory: Bronchitis, Pneumonia, Difficulty Breathing, Wheezing, Chronic Cough

Gastrointestinal: Nausea, Vomiting, Diarrhea, Constipation, Weight Gain or Loss, Blood in Stool, Excessive Gas, Loss of appetite

Genitourinary: Chronic Kidney or Bladder Infections, Problem Voiding, Black Stool, Dark or Bloody Urine, Discharge from Penis or Vagina, Pain with Urination

Gynecologic: Irregular or Painful Periods, Absence of Period if Not Menopause, Vagina Discharge

Do your Legs swell? ___Yes ___No

Do you have Back problems or have had a back injury? ___Yes ___No



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PATIENT CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment for third-party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications

I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time; and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operation. I also understand that you are not required to agree to my requested restrictions. However, if you agree; you are bound to abide by such restrictions.

I give my permission for this office to leave a message on my answering machine and/or with a family member.

I understand that I may revoke this consent in writing at any time; except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____ Date: _____

Relationship To Patient: _____