Personal Information

Ronald Belczyk, DPM, Inc.
Patient Information

Phone: (747) 263-9696
Fax: (818) 475-1406

Last Name: ____________________ First Name: _______________ M. I. ___ ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Date of Birth: ___ /___ / _____ Age: ____ Sex: ☐ Male ☐ Female

Address: ______________________________ City: _________________ State: ____ Zip: ________

Social Security: ____ - ____ - ______ Email Address: ________________________________

Home Phone: (____) ____ - ______ Cell Phone: (____) ____ - ______

Work Phone: (____) ____ - ______

Spouse / Child Name: _____________________ Phone: (____) ____ - ______

Race: ________________ Ethnicity: ________________ Language(s): ______________________

Pharmacy: Name: _________________________ City: ________________ Phone: (____) ____ - ______

Treating Physicians

Referring Physician: _______________________ Primary Care Physician: ________________________

Other Physicians Providing Care: ____

Insurance Information

Primary Insurance: ____________________________ I.D. Number: __________________________
Name of Insured: _____________________________ Date of Birth: ___ /___ / _____
Relationship to Insured: ________________________

Secondary Insurance: __________________________ I.D. Number: __________________________
Name of Insured: _____________________________ Date of Birth: ___ /___ / _____
Relationship to Insured: ________________________

Emergency Contact

Name: ___________________________ Relationship: _________________________
Address: _________________________ City: _________________ State: ____ Zip: ________
Home Phone: (____) ____ - ______ Cell Phone: (____) ____ - ______

I hereby consent to and authorize the performance of all treatments, surgery, and all medical services by Ronald J. Belczyk, DPM, Inc. I accept full financial responsibility for all medical/surgical services performed on my behalf that are not covered by my insurance company. **All co-payments, deductibles and non-covered services are due at the time of service**, unless prior arrangements have been made. I hereby authorize the provider and his assistants to release all information necessary acquired in the course of my examination and/or treatment to secure payment for services. I hereby authorize my insurance company to pay benefit directly to Ronald J. Belczyk, DPM, Inc.

X_______________________________ _______________________________ _____________
Patient or Guardian's Signature Patient or Guardian Name Printed Date

Ronald Belczyk, DPM, Inc.
Medical History Form

Phone: (747) 263-9696
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Patient Name: ______________________ Date: ______________

Date of Birth: ___ /___ / _____ Age: ____ Sex: ☐ Male ☐ Female

Referring Physician: ______________________
Ambulation: ☐ Walking ☐ With cane/walker ☐ Wheel Chair ☐ Stretcher

BP: _____mmHg P:_____B/mn R:_____B/mn T:_____F Ht:_____ Wt:_____Lbs

Chief Complaint History

Please describe the reason for your visit:
____
____

Date of injury/condition onset and duration: ______________________________________

Describe your symptoms: ☐ Pain ☐ Swelling ☐ Burning ☐ Tingling ☐ Numbness
☐ Pain at rest ☐ Pain with activity ☐ Other Symptoms

What treatments have you tried? ☐ Orthotics ☐ Medications ☐ Injections ☐ Physical Therapy
☐ Surgery ☐ None ☐ Other Treatments: ______________________________________

Health History

☐ Diabetes ☐ Hyperlipidemia ☐ Coronary Heart Disease
☐ Hypertension ☐ CVA / TIA
☐ No
☐ Yes ☐ Hx of MI ☐ Stable Angina
☐ Unstable Angina

☐ Stress Test ☐ No ☐ Yes: ☐ Normal ☐ Positive

☐ Renal ☐ No ☐ Yes ☐ Dialysis (circle) Mon. Tues. Wed. Thurs. Fri. Sat.

Social History

Exercise: ☐ No ☐ Yes ____ x/week
Smoking: ☐ Current ____#pack/day ☐ Prior: Quit date ___________ ☐ Never
Alcohol: ☐ No ☐ Yes ☐ Drinks ____#pack/day
Pregnant: ☐ No ☐ Yes

Family History

Mother: ☐ Alive ☐ Deceased Medical History: ______________________________
Father: ☐ Alive ☐ Deceased Medical History: ______________________________
Sibling: Medical History: ____

- CONTINUE -

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Medical History Form

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Medications

Medications	Dose	Frequency

Pharmacy

Name & Location	Phone	Fax

Allergies

- ☐ Penicillin
- ☐ Sulfa
- ☐ Seafood
- ☐ Others:
- ☐ Latex
- ☐ Iodine ☐ Skin ☐ IV
- ☐ Adhesive/Tape
- ☐ Local Anesthetic
- ☐ Novocaine ☐ Lidocaine
- ☐ General Anesthesia
- ☐ Codeine
- ☐ Anti-inflammatories
- ☐ Aspirin

Surgical History

Surgical Procedure	Year	Surgeon or Hospital	Complications?

- STOP -

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Review of System

Name: ____________________________ **Date:** ___________

Cardiac:	☐ Chest Pain/Tightness ☐ Artrial Fibrillation ☐ Heart Murmur	☐ Congestive Heart Failure ☐ Mild ☐ Moderate ☐ Severe	☐ Palpitation ☐ Pacemaker: ____Year
Respiratory/ Lungs:	☐ Cough / Sputum ☐ Painful Respiration ☐ Sleep Apnia ☐ Tuberculosis	☐ Shortness of Breath ☐ Blood in Sputum ☐ Asthma ☐ Emphysema	☐ C O P D ☐ On Meds ☐ On Oxygen ☐ Not treated
Vascular:	☐ Cramps Walking ☐ Leg Pain ☐Right☐Left ☐ Swelling ☐Arms☐Legs ☐ Foot ☐ Toes: ☐ Ulcer ☐ Infection ☐ Vein Stripping	☐ IVC Filter___Year ☐ Angioplasty for Legs ☐ Bypass Surgery for legs ___Year ☐ Amputation: ☐BK ☐AK ☐ Change in Skin Color	☐ Numb/Tingling ☐Arms☐Leg ☐ Poor Circulation ☐ Gangrene ☐ Blood Clots ☐ History of Aneurysm ☐ Surgery for Neck arteries
Endocrine:	☐ Diabetes Mellitus	☐ Hormone Replacement Therapy	☐ Thyroid Problems ________________
Neurologic:	☐ Stroke ☐ Blurred Vision ☐ Multiple Sclerosis	☐ TIA ☐ Syncope ☐ Fainting	☐ Headache ☐ Dizziness ☐ Seizure
Genitourinary:	☐ Renal Failure ☐ Blood in Urine ☐ Impotence	☐ Dialysis ☐ Nocturia ☐ Discharge	☐ Pain on Urination ☐ Frequency
Gastro-Intestinal:	☐ Abdominal Pain ☐ Black Stools ☐ Constipation	☐ Poor Appetite ☐ Nausea / Vomiting ☐ Hepatitis A B C	☐ Weight Loss ☐ Diarrhea ☐ IBS
Hematologic/ Oncologic:	☐ Tumor Growth / type: ____________________ ☐ Cancer / type: ___________ /____ Year	☐ Chemotherapy ☐ Radiation Therapy ☐ Enlarged Lymph Nodes	☐ Anemia ☐ AIDS ☐ HIV
Musculoskeletal:	☐ Back Pain ☐ Joint Replacement	☐ Neck Pain ☐ Joint Swelling	☐ Polymyalgia ☐ Arthritis