Scott A. Groat, D.P.M.
151 S. Mary Esther Blvd., Suite 510 Mary Esther, FL 32569

DATE:_____ **NAME:**_____ **DOB:**_____

SS#:_____ **Marital Status: S M D W Spouse Name:**_____ **Email:**_____

Address:_____ **City:**_____ **Zip:**_____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

Employer:_____ **Occupation:**_____

Primary Insurance:_____ **Secondary Insurance:**_____

Policy #:_____ **Policy #:**_____

Primary Care Physician:_____ **Referred By:**_____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST

ENT
Nose Bleeds
Difficulty Swallowing
Difficulty Chewing
Visual Problems
Glaucoma
Cataracts
Glasses
Contact Lenses
Hearing Problems
Thyroid Problems
Sinus Problems
Other:_____

NEUROLOGICAL
Numbness arms/legs
Fainting
Dizziness
Seizures/Epilepsy
Stroke
Headaches
Migraines
Other:_____

CARDIOVASCULAR
Chest Pain
Heart Attack
Heart Disease
High Blood Pressure
Abnormal EKG
Swelling of feet/ankles
Abnormal heart rhythm
Rapid heart rate
Pacemaker
Blood clot in leg
Other:_____

RESPIRATORY
Asthma
Emphysema
Lung Disease
Abnormal chest x-ray
Shortness of Breath
Use oxygen at home
Tuberculosis
Blood clot in lung
Chronic cough
Blood in sputum
Other:_____

SKELETAL/MUSCULAR
Rash
Gout
Arthritis
Sore not healing
Limited motion in joint
Back problems
Other:_____

GASTROINTESTINAL
Abdominal pain
Ulcer in stomach
Hiatal hernia
Nausea or vomiting
Constipation
Diarrhea
Change in appetite
Unexplained weight loss/gain
Heartburn
Gallbladder problems
Other:_____

GENITOURINARY
Difficulty urinating
Frequent infections
Kidney problems
Prostate problems
On dialysis
Abnormal female bleeding
Other:_____

HEMATOLOGICAL
Anemia
Bleeding disorder
Hemophilia
Sickle cell anemia
HIV positive
Other:_____

LIVER
Hepatitis
Yellow skin/Jaundice
Other:_____

DIABETIC: Yes No
Oral or Insulin
Year Diagnosed:_____

SOCIAL HABITS
Use of alcohol:
Never
Rarely
Moderate
Daily

Use of tobacco:
Never
Previous, but quit
Current packs/day____

ALLERGIES
Adhesive tape
Antibiotic_____
Aspirin
Codeine
Demerol
Iodine
Motrin/Advil
Sulfa
Other:_____

FAMILY HISTORY:

	Bunions	Cancer	Diabetes	Gout	Heart Disease
	Mother	Mother	Mother	Mother	Mother
	Father	Father	Father	Father	Father
	Sister	Sister	Sister	Sister	Sister
	Brother	Brother	Brother	Brother	Brother

Major Surgeries:_____

Medications:_____
Please list medications or attach photocopy if available

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Name:_____ **Date:**_____

Reason for today's visit:_____ **Onset:**_____

Age:_____ **Height:**_____**ft** _____**inches** **Weight:**_____

Previous Treatment: None, rest, ice, elevation, medication/anti-inflammatory, changing shoes, inserts,

other:_____

Pain Quality: Sharp, dull, aching, burning, tingling, stabbing, throbbing, deep, frequent, constant,

other:_____

Severity: No pain, pain is worse sitting/lying, pain is worse standing, pain is worse walking

Pain right now is:_____/10, pain at its greatest is_____/10 when I am_____

Pain is worse: Morning, Daytime, Nighttime, Random, Gradual, Recurrent, Other:_____

FINANCIAL POLICY

Payment for services is due at the time service is rendered if we are not a participating provider with your insurance carrier. If we are a participating provider and your yearly deductible is satisfied then your responsibility would be your co-payment or percentage amount. We accept cash, check, MasterCard, Visa, and Discover. We will be happy to process your insurance claim form for your reimbursement.

INSURANCE AUTHORIZATION

I authorize the processing of medical insurance by Dr. Scott A. Groat. I further authorize the release of medical information necessary to process this claim. I recognize my financial obligation of payment, co-insurance, deductible and non-covered services that may be required.

ACKNOWLEDMENT OF RECIPT OF NOTICE OF PRIVACY PRACTICE

Notice of Privacy Practices posted on wall in waiting room. A copy is available should you desire one. I have acknowledged that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

Signature:_____ **Date:**_____

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Authorization for Release of Information

I, _____, authorize the release of information including medical or surgical care rendered to me and any financial information related to the care given to me.

Below are the person(s) and relationship that I authorize information released to.

1._____ Relationship: _____

2._____ Relationship: _____

3._____ Relationship: _____

Medical information may be communicated by phone message to:

☐ My home ☐ My work ☐ My cell phone number

If unable to reach me, please select one of the following:

☐ You may leave a detailed message with the person answering the phone.

☐ Please leave a message asking me to return your call.

What is the best time to reach you (Include the day and hours)

Authorization for Retrieval of Prescription History

Dr. Scott Groat utilizes an Electronic Medical Record System that can retrieve information about your prescription history. This history gives the physician complete information that will assist them in providing the best care and preventing possible prescription interactions.

☐ I authorize Dr. Scott Groat to retrieve my prescription history.

☐ I do not authorize Dr. Scott Groat to retrieve my prescription history.

Pharmacy and location:_____

_____ _____

Signature of Patient, parent, guardian, or legal representative **Date**
