Cimaglia Foot Care
Cathy Cimaglia, DPM

805 E. Oldtown Road, Suite B
Cumberland, MD 21502

880 Memorial Drive
Oakland, MD 21550

301-722-6166
cimagliafootcare.com

Patient Information

Date: _____

_____
Patient Name

_____
Home Address

_____
City State Zip code

_____@_____
Email address

_____
Social Security#

_____
Date of Birth

_(____)_____
Home Phone Number

_(____)_____
Cell Phone Number

Circle for how you would prefer to be alerted for future appointments to the office
Text Email Phone call

Sex: ___F ___M Race:_____

Marital Status: __M __S __D __W
Employment Status:_____
Employer:_____
Occupation:_____
Student __Y __N

_____
Emergency Contact Name

_____
Relationship

_(____)_____
Phone Number

_____ _____
Family Doctor Date last Seen

_____ _____
Pharmacy Name Location

How did you hear about us?_____

_____
Primary Insurance

_____
Secondary Insurance

_____ _____
Name of Policy Holder **Date of Birth**

Authorization for Treatment, Assignment of Benefits, Medicare and Medical Assistance
I authorize CATHY A. CIMAGLIA, DPM to apply for benefits on my behalf for services rendered by CATHY A. CIMAGLIA, DPM. I request payment from my insurance company be made directly to CATHY A. CIMAGLIA, DPM. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information for this or any related claims. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing here in relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered. In the event of any outstanding balance, this matter will be referred to collections. In the event this statement is referred to collection, I understand that I will be responsible for the cost of collections, including attorney's fees and court costs.
Medicare and Medical Assistance Only: I authorize the release to the Social Security Administration and Health Care Financing Administration or its intermediaries any information needed for this or related claims. I understand that *I am responsible for payment of deductibles* or if Medicare or Medical Assistance determines that the care I received is a non-covered service. I also give permission to Cimaglia Foot Care to release information regarding my care to any party involved in my healthcare. **I understand and accept the terms listed above.**
I acknowledge that I was provided a copy of the ***NOTICE OF PRIVACY PRACTICES*** and that I have read (or had the opportunity to read if I so chose) and understand the NOTICE. _____(initial)
I have also *read* and *understood* the ***PATIENT FINANCIAL POLICY*** and agree to comply with this policy. _____(initial)

Patient's Signature: _____ Date _____

Parent or Legal Guardian: _____ Date _____
(for minors or medial power of attorney)

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Reason for your visit today: _____
When did it start? _____ Result of an injury? __Y __N Date of Injury: _____
Have you had x-rays, MRI or other studies performed for this issue? __Y __N
Have you seen another provider for this problem? __Y __N If yes, then who? _____
Height: _____ **Weight:**_____ **Shoe Size:**_____
Medications: (Do not fill out if you have brought a medication list with you)

_____

_____

_____

Allergies

__No Known Drug Allergies
__Adhesive Tape
__Aspirin
__Codeine
__Ibuprofen (Motrin)
__Iodine
__IV Contrast
__Lidocaine
__NSAIDs
__Local Anesthetics
__Novocain
__Penicillin
__Sulfa Drugs
Others:_____
_____

Surgical History

__Amputation R L
__Ankle Surgery R L
__Back Surgery
__Bunion Surgery R L
__Hammertoe R L
__Heart Surgery
__Knee replaced R L
__leg vascular surgery R L

Other: _____
_____

Past Medical History

__anemia
__anxiety disorder
__arthritis, osteoarthritis
__asthma
__blood clots in leg
__bronchitis
__cancer type:_____
__congestive heart failure
__COPD
__dementia
__depression
__emphysema
__fibromyalgia
__gastric reflux
__gout
__heart disease
__hepatitis type:_____
__high blood pressure
__HIV positive
__kidney disease
__liver disease
__lupus (SLE)
__multiple sclerosis
__neuropathy
__osteoporosis
__Parkinson's disease
__rheumatoid arthritis
__stroke
__thyroid disorder
__type 1 diabetes mellitus
__type 2 diabetes mellitus
Other: _____
_____

Social History

Do you **smoke**? __Y __N
If yes, how much _____
Quit? __Y __N
When?_____

Do you use any other tobacco products? __Y __N
What type?_____

Do you use **alcohol**? Y N
If yes __beer __liquor
Check which one applies:
__heavy __moderate
__social

Do you exercise regularly?
__Y __N

Please list any serious illnesses in your family:

_____
_____
_____
_____

WOMEN:
Are you pregnant? __Y __N
Are you nursing? __Y __N

Please check if you are currently having any of these symptoms

__fatigue
__fever
__chills
__recent weight loss
__recent weight gain
__vision loss
__hearing loss
__nosebleeds
__varicose veins
__swelling in legs
__leg pain with exercise
__shortness of breath
__diarrhea
__heartburn
__rash
__dry skin
__nail changes
__ingrown toenail
__numbness in feet
__burning sensation in feet
__tingling in feet
__back pain
__ankle pain
__foot pain
__difficulty walking
__muscle weakness
__increased thirst
__frequent urination
__anxiety
__depression
__taking blood thinners

Did you receive a flu shot this year? __Y __N
Is your pneumonia vaccine up to date? __Y __N
Any falls in the past year? __Y __N If yes, did you suffer any injuries? _____
Are you taking blood thinners? __Y __N