# FRANCISCO J. OLIVA DPM

801 Monterey Street Suite 203 Coral Gables, Fl 33134 (305) 648-3680 www.olivapodiatry.com

NAME ..............................................................................................................

ADDRESS ..............................................................................................................

CITY ......................................................STATE .......................  ZIP ......................................

HOME PHONE (............).......................-.......................... EMPLOYER..........................................

WORK ADDRESS..............................................................................................................

WORK PHONE (............).....................-....................... EXT..........................

DATE OF BIRTH ................./................./..............  MALE................  FEMALE...............

SOCIAL SECURITY #..............................................................................................................

INSURANCE ..............................................................................................................

INSURANCE #..............................................................................................................

REFERRED BY:..............................................................................................................

WHO IS YOUR FAMILY DOCTOR?..............................................................................................................

ARE YOU IN GOOD HEALTH?  YES  NO  DO YOU HAVE BLEEDING PROBLEMS?  YES  NO

DO YOU HAVE DIABETES?  YES  NO  IF SO, WHAT TYPE?..............................................................

WHAT IS YOUR MAIN FOOT COMPLAINT?..............................................................................................................

MEDICAL CONDITIONS ..............................................................................................................

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING ..............................................................

PLEASE LIST/CIRCLE ANY ALLERGIES YOU MAY HAVE

NOVOCAINE  PENICILLIN  CORTISONE  ASPIRIN

LIST ANY PREVIOUS OPERATIONS:..............................................................................................................

HAVE YOU EVER BEEN TREATED FOR:  HEART TROUBLE  ASTHMA

EPILEPSY  RHEUMATIC FEVER  KIDNEY OR LIVER INVOLMENT

DO YOU SMOKE?  YES  NO  DO YOU USE ALCOHOLIC BEVERAGES? ..........................................

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NOMBRE ............................................................................................................

DIRECCION............................................................................................................

CIUDAD ..........................................................ESTADO ...................... ZIPCODE ..........................................

TELEFONO (................)..........................-........................... TRABAJO..........................................................

DIRECCION DE TRABAJO............................................................................................................

TELEFONO DE TRABAJO (.........................)...............................-......................................... EXTENSION. ..........................

FECHA DE NACIMIENTO ................./................./...............

NOMBRE DE SEGURO MEDICO ............................................................................................................

NUMERO DE SEGURO MEDICO............................................................................................................

REFERIDO POR:............................................................................................................

¿QUIEN ES SU DOCTOR DE FAMILIA?............................................................................................................

¿ESTA UD. EN BUENA SALUD? SI NO ¿TIENE UD. ALGUN PROBLEMA DE SANGRAMIENTO? SI NO

¿TIENE UD. DIABETES? SI NO ¿QUE TIPO?............................................................................................................

CONDICIONES MEDICAS ............................................................................................................

¿QUE MEDICAMENTOS ESTA UD. TOMANDO? ............................................................................................................

¿DE QUE ALERGIAS PADECE UD?

NOVOCAINA PENICILINA CORTISONA ASPIRINA

TRANQUILIZADORES CINTA ADHESIVA LANA OTRA(S)............................................................

¿CUALES CIRUGIAS HA TENIDO?:............................................................................................................

¿HA UD. RECIBIDO TRATAMIENTO PARA...? PROBLEMAS DE CORAZON ASMA

EPILEPSIA FIEBRE REUMATICA RIÑONES HIGADO

¿FUMA? SI NO ¿CONSUME BEBIDAS ALCOHOLICAS? SI NO

¿PARTICIPA UD. EN ACTIVIDADES FISICAS? SI NO

TIPO:............................................................................................................

¿CUAL ES SU PROBLEMA PRINCIPAL DE LOS PIES?............................................................................................................

Reorder 8/09 OBS 1-800-634-1876

Francisco J. Oliva, DPM, PA
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Acknowledgement of Receipt
Of
Notice of Privacy Practices

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 understood the notice. Francisco J. Ol.iva, DPM, PA reserves the right to modify the privacy practices outlined in the notice

I have received or read a copy of the Notice of Privacy Practices for Francisco J. Oliva, DPM, PA.

______________________________

***Patient Name (please print)***

______________________________

***Signature of Patient***

______________________________

Date

______________________________

Signature of Patient Representative
(Required if patient is a minor or an adult who is unable to sign this form

______________________________

Relationship of Patient Representative to Patient