



LECOM Englewood Podiatry

Patient Name _____ Local /Home Phone (____) _____
Cellular Telephone (____) _____

Caregiver/Guardian Name & Phone# _____ (____) _____

Permanent Address _____
Street City State Zip Code

Other Address _____ (____)
Street City State Zip Code Telephone#

Florida "Snowbirds" - Dates you are in Florida: Arrival ____/____/____ Departure ____/____/____
Month Day Month Day

Birthdate ____/____/____ SS# _____ Female ____ Male ____ Unassigned ____

Email Address (required to access your electronic health records): _____

Preferred method to confirm appointments: ____ cell phone ____ home phone If Available

Preferred Pharmacy: _____ (____)
Name Street City State Zip Telephone#

Marital Status (check one) Single ____ Married ____ Spouse Name/# _____ (____)

Div ____ Wid ____ Sep ____ Emergency Contact (other than spouse) _____ (____)
Name Telephone#

Employed? No /Yes Occupation _____ (____)
(circle one) Title Telephone#

Employer _____ (____)
Employer Name Street City State Zip Telephone#

Is your injury related to work/auto accident/litigation? No ____ Yes ____ Date of injury ____/____/____
(please circle one)

How did you learn of our office? Ref by Dr. _____ Friend/Other Patient (who?) _____

Internet ____ Sign ____ Ins Co ____ Telephone Book ____ Ad/Newspaper ____ Other ____

The following data is mandated for "Meaningful Use" created by the US Federal Government using § 170.207(f) OMB standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, Statistical Policy Directive No. 15, Oct 30, 1997;

Preferred Language: English ____ Spanish ____ Other ____

Ethnicity: Hispanic/Latino ____ Not Hispanic/Latino ____ Decline ____

Race: (check one)	African American/Black	Caucasian/White	Alaskan Native	American Indian
Asian	Chinese	Filipino	Guamanian	Hawaiian Native
Hispanic	Japanese	Korean	Multiracial	Pacific Islander
Samoan	Vietnamese	Unknown	Decline	Other

I hereby give permission to Dr. Edwin Bautisa and his associate/s to evaluate, diagnose and administer treatment and to perform such minor operative procedures deemed necessary in the diagnosis and/or treatment of my lower extremity condition. I will notify you in case of any changes in my health status or the above information.

Signature of Patient (or Parent/Guardian, if Minor)

Date

Witnessed