WELCOME TO THE OFFICE OF

DR. DAVID W. GOOCH, D.P.M.

DATE _____

PATIENT'S NAME _____

DATE OF BIRTH _____SOCIAL SECURITY #_____

ADDRESS_____

CITY_____ STATE_____ ZIP _____

E-MAIL ADDRESS_____@_____

Our office provides the service of "reminder calls". To protect your privacy, please indicate how you would prefer this to be done.

Cell Number:_____ Leave Message? (circle one) Yes No

Automated Text reminders? (circle one) Yes No

Home Number: _____ Leave Message? (circle one) Yes No

Work Number: _____ Leave Message? (circle one) Yes No

PHARMACY _____ CROSS STREETS _____ ZIP CODE_____

SEX MALE FEMALE

( ) WHITE ( )HISPANIC/LATINO ( )ASIAN ( ) AFRICAN AMERICAN

( ) AMERICAN INDIAN ( ) PACIFIC ISLANDER

OCCUPATION EMPLOYER _____

SPOUSE'S NAME _____ DATE OF BIRTH _____

SPOUSE'S EMPLOYER PHONE _____

EMERGENCY CONTACT PERSON_____

CONTACT PERSON PHONE _____ RELATIONSHIP _____

WHO REFERRED YOU TO OUR OFFICE? _____

HAVE YOU SEEN A PODIATRIST BEFORE? YES NO

IF YES, DOCTOR'S NAME _____ LAST VISIT_____

PRIMARY DOCTOR'S NAME _____ PHONE _____

ARE YOU CURRENTLY UNDER THE CARE OF A DOCTOR OR SPECIALIST? YES NO

IF YES, PLEASE EXPLAIN _____

PRESENT COMPLAINT YOU ARE HAVING WITH FOOT/ANKLE?

_____

HEIGHT _____ WEIGHT _____ SHOE SIZE_____

ATHLETIC ACTIVITIES IN WHICH YOU PARTICIPATE AND FREQUENCY

_____

DO YOU HAVE A FAMILY HISTORY OF DIABETES? YES NO

DO YOU SMOKE? YES NO PACKS PER DAY_____ #OF YEARS _____

SMOKED PREVIOUSLY? YES NO PACKS PER DAY _____ #OF YEARS_____

DO YOU DRINK ALCOHOL? YES NO AMOUNT_____

DO YOU HAVE ANY OF THE FOLLOWING?

AIDS/HIV_____	ANEMIA_____	ARTHRITIS_____
ASTHMA_____	BACK PAIN_____	BLEEDING TENDENCIES_____
CANCER_____	EPILEPSY_____	CIRCULATORY PROBLEMS___
DIABETES_____	HEPATITIS_____	CHEMICAL DEPENDENCY____
STROKE_____	TUMORS_____	HIGH BLOOD PRESSURE____
ULCERS_____	HEART DISEASE_____	NERVOUSNESS_____
KIDNEY TROUBLE_____	PHLEBITIS_____	RESPIRATORY DISEASE_____
NEUROPATHY_____	TUBERCULOSIS_____	LIVER DISEASE_____
GOUT_____	VARICOSE VEINS_____	OTHER_____

FAMILY HISTORY:

Please indicate if a family member has/ had any of the following by specifying the family member and type.

Diabetes ☐ Mother ☐ Father ☐ Brother ☐ Sister

Heart Disease ☐ Mother ☐ Father ☐ Brother ☐ Sister Type: _____

Cancer ☐ Mother ☐ Father ☐ Brother ☐ Sister Type:_____

Kidney Disease ☐ Mother ☐ Father ☐ Brother ☐ Sister

High Blood Pressure ☐ Mother ☐ Father ☐ Brother ☐ Sister

MEDICATIONS	DOSAGES / FREQUENCY

SEE ATTACHED LIST OF MEDICATIONS I BROUGHT TO MY VISIT TODAY ☐

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ Yes ☐ No. If yes, please list below:

☐ Aspirin ☐ Codeine ☐ Iodine ☐ Penicillin ☐ Sulfa ☐ Others_____

Type of Reaction_____

IMMUNIZATION:

Pneumovax (pneumonia vaccine) Date: _____

Influenza (Flu Shot) (date of last shot) Date: _____

HAVE YOU FALLEN IN THE PAST YEAR? _____ DO YOU FEEL UNSTEADY WHEN STANDING/ WALKING? _____

RECENT SURGERIES OR HOSPITALIZATIONS:

_____

To the best of my knowledge the above information is complete and accurate. I authorize the release of any medical, psychiatric, or other information necessary to process any claim and to provide information to another health care provider when necessary to coordinate treatment. I also authorize payment of benefits to Gooch Foot & Ankle Specialists. I fully understand that if my insurance denies payment for any service defined as "non-covered", I will be responsible for that amount due, including annual deductibles, co-payments, insurance rejections, cash charges, etc. In the event this account must be placed with a collection agency, patient or responsible party agrees to pay all collection costs. I acknowledge that I was provided a copy of the notice of privacy practice and I have/ had the opportunity to read and understand the notice.

PATIENT SIGNATURE_____ DATE _____

Consent to Use Scribe Software powered by Artificial Intelligence during Medical Encounters

Dear Patient,

We are committed to providing the best possible care for you, and as part of this commitment, we are continually looking for ways to enhance our services.

We would like to inform you about a new technology that we are using called AI Scribe which is an artificial intelligence (AI) tool that assists us during patient encounters by generating clinical notes based on our conversations. This tool allows us to focus more on you, the patient, and less on computer documentation.

What is AI Scribe Software?

AI Scribe is a tool that listens to the conversation during a medical consultation and generates a written summary or "note" based on that conversation. This note is then reviewed and approved by your doctor.

How will this affect you?

The AI Scribe tool does not interact with you directly. It merely listens to the conversation and creates a summary. This can allow the doctor to focus more on the visit and less on taking notes.

Data Privacy and Confidentiality

We want to assure you that your privacy is our utmost priority. The AI Scribe tool adheres strictly to Health Insurance Portability and Accountability Act (HIPAA) compliance guidelines to ensure your data is secured and protected. Only the healthcare professionals involved in your care will have access to these notes and notes are deleted after each visit.

Your Consent

Your participation is completely voluntary. If you agree to the use of AI scribe software during your consultations, please sign and date the form below. If you have any questions or concerns, please feel free to discuss them with us.

I, _____, consent to the use of AI Scribe Software during my medical encounters/appointments.

Signature: _____ Date: _____

Thank you for your understanding and cooperation.

David Gooch, DPM, AACFAS