WELCOME

Thank you for selecting our healthcare team! We strive to provide you with the best possible healthcare. To help us meet your healthcare needs, **please print** and fill out these forms completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

CONFIDENTIAL PATIENT INFORMATION

Name ____ Nickname ___________________
First M.I. Last

Date of Birth ______________ Home Phone ( ) - __________ Cell __________________

Address _______________________________ City ____________ State _____ Zip___________

SSN # (Last 4 Digits) __________ Who is responsible for the bill? ______________________

Patient's Employer: ________________ Work Phone ________________ Ext.______

Circle Status: **M**inor **S**ingle **M**arried **W**idowed **D**ivorced

Circle Sex: **F**emale **M**ale

How did you hear about our office? ____

* Please bring your insurance card to the front desk, if you would like us to submit your claim. As a courtesy, we will be happy to file your insurance for you at no charge; however, payment is required at the time of service. *

FINANCIAL ARRANGEMENTS

HEALTH INSURANCE COMPANY ____

SUBSCRIBER NAME ___________________ Sub ID #____________________ Date of Birth_________

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

___CASH ___ CREDIT CARD ___ PERSONAL CHECK

___ I wish to discuss the office's payment policy.

I authorize and request my insurance company to pay directly to the doctor or the doctor's group insurance benefits otherwise payable to me.

I also understand that I am financially responsible for all my or my dependents charges whether or not covered by insurance.

X___________________________________ __________________
Signature of patient or guardian if minor Date

Name: ______________________________ Date: ___________________

Age: ______Weight: _______ Height: _______ Shoe Size: ______________

What kind of foot problem are you having? ___________________________

List all medications you are currently taking: ____

____

Is there any personal or family history of diabetes? ____ Yes ____No

Athletic activities in which you participate (please list and indicate frequency): ____________________

____

Your Occupation: ____

Do you smoke? Yes / No Amount? _________________ Drink Alcohol? Yes / No Amount? _________

Family Physician's Name: _________________ Date last seen: _________

In Case of Emergency, Contact:

Name: _________________________________Relationship:_______________

Home Phone: ___________________________Work Phone : ______________

Have you been treated for a foot or ankle problem in the Past? ___Yes ____ No

If Yes; What was the problem? _____________________________ Doctors Name: _______________

Please check if you are allergic to any of the following Medications Listed Below:

☐ I Have No Allergies to Any Medications

☐ Aspirin	☐ Novacaine	☐ Iodine	☐ Codeine	☐ Sedatives
☐ Penicillin	☐ Sulfa	☐ Narcotics	☐ Barbiturates	☐ Anesthetics
☐ Adhesive Tape	☐ Antihistamines	☐ Other (specify) ____________________		

Please Check If You Have Any Of The Following:

☐ Diabetes	☐ Asthma	☐ Epilepsy	☐ Phlebitis	☐ Rheumatic Fever
☐ Tumors	☐ Cancer	☐ Kidney Disease	☐ Anemia	☐ Heart Problems
☐ Thyroid	☐ Stroke	☐ Glaucoma	☐ AIDS/HIV	☐ Neuromuscular
☐ Lung Ds.	☐ Liver Disease	☐ Headaches	☐ Arthritis	☐ Bleeding Problems
☐ Heart Burn	☐ Hypertension	☐ Ulcers	☐ TB	☐ Heart Valve Ds.
☐ Hepatitis	☐ Transfusions	☐ Nervousness	☐ DVT	☐ Fibromyalgia
☐ Venereal Disease	☐ Poor Healing	☐ Back Problems	☐ Chronic Fatigue	

Women: Are You Currently Pregnant? ☐ Yes ☐ No

Are You Currently Taking Birth Control Pills? ☐ Yes ☐ No

Other Medical Problem Not Listed Above: ____

____

List Any Operations Which You Have Had In The Last 5 Years: ______________________________

____

List Any Hospitalizations Which You Have Had In The Past 5 Years: __________________________

____