Welcome to Our Office!

Patient's Name:_____
Mailing Address:_____
City, State, Zip:_____
Patient's Home Phone: ( )_____Work/Cell: ( )_____
SS#_____Date of Birth:_____
Sex:_____Male_____Female Marital Status: S M D W O
E-Mail Address:_____
Occupation:_____Spouse's Name:_____
Family Physician:_____Phone# ( )_____
How were you referred to our office?_____

Insurance Information

Name of Insurance Company:_____
Policy Number:_____
Secondary Insurance:_____
Policy Number:_____
Name of Policy Holder:_____Date of Birth:_____

Personal Information

Is this your first visit to a Podiatrist?_____If not, when last?_____
Presently under physician's care? List_____
_____
List any allergies you have to medication:_____
Allergic to tape:_____
Do you smoke?_____Consume alcohol?_____
Have you suffered any serious injuries to feet, ankles, legs?_____
_____
Do you engage in sports? Kinds?_____
Have you been treated for: (Please Check)

_____Diabetes	_____Heart Disease	_____Stroke
_____Arthritis	_____Epilepsy	_____High Blood Pressure
_____Fainting	_____Asthma	_____Prolonged Bleeding
_____Anemia	_____Tuberculosis	_____Hearing Difficulties
_____Dizziness	_____Gout	_____Nervous Disorders
_____Eye Disease	_____Liver Disease	_____Kidney Disease
_____AIDS	_____Thyroid Disease	_____HLA-B27 Complex
_____Rheumatic Fever	_____High Cholesterol	

Please List All Medication:_____
_____
Serious illnesses or operations:_____
_____
Family History:_____

I authorize payment of medical benefits to named providers for professional services rendered.
I authorize the release of any medical information necessary to process this claim
Patient's or Legal Guardian's signature:_____
Date Signed:_____

Dr. Michael E. Newman and Dr. Denise A. Kohler

RACE (Optional): White ___ AfrM/Amer/Black ___ Asian___ Native Hawaiian or Other Pacific Islander ___ American Indian___ Alaska Native ___

ETHNICITY (Optional): Hispanic or Latino ___ Not Hispanic or Latino ___

INSURANCE INFORMATION: Please present your card(s) to a staff member to copy your insurance and group numbers

PRIMARY MEDICAL INSURANCE COMPANY _____

SECONDARY MEDICAL INSURANCE COMPANY _____

SUBSCRIBERS NAME _____ **RELATIONSHIP TO PATIENT** _____

SUBSCRIBERS DATE OF BIRTH ____ /____ / ____ **EMPLOYER** _____

PRIMARY CARE/FAMILY PHYSICIAN OR GROUP _____

MEDICATIONS: PLEASE LIST ANY MEDICATIONS THAT YOU ARE TAKING: ___ **NOT TAKING ANY MEDICATIONS**

NAME: _____ DOSE: _____ FREQUENCY_____

NAME: _____ DOSE: _____ FREQUENCY_____

NAME: _____ DOSE: _____ FREQUENCY_____

NAME: _____ DOSE: _____ FREQUENCY_____

NAME: _____ DOSE: _____ FREQUENCY_____

LIST ANY OTHERS _____

PHARMACY NAME AND PHONE (If Known) _____

ADDRESS (If Known) _____

FOR DIABETICS – LAST DR. VISIT _____ **BLOOD SUGAR** _____ **A1c** _____ **LAST DATE** ___ /___ /____

SOCIAL HISTORY – DO YOU USE OR HAVE YOU USED ANY OF THE FOLLOWING:

SMOKING HISTORY:___NEVER ____ FORMER SMOKER ____CURRENT EVERYDAY SMOKER ____OCCASIONAL SMOKER

ALCOHOL USE: ____YES ____ NO ____ SOCIAL ____ MILD ____ MODERATE ____ HEAVY ____ QUIT

LAST SEEN BY A PODIATRIST: ____ / ____ / _____ **NEVER** ____ **FEMALES**: CURRENTLY PREGNANT ___YES ___NO

HOW WERE YOU REFERRED TO OUR OFFICE:

____Primary Care Physician/Family Physician ____Internet ____Web Site ____Existing Patient ____Church Bulletin ____Pediatrician

____Insurance or Hospital Referral Service ____Other Specialist ____Newspaper or other advertisement ____Phone Book

Other_____

I certify that the above information is correct.

PATIENT SIGNATURE _____ **DATE** _____ / _____ / _____