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:_____