

## PATIENT INFORMATION

PAYMENT IS EXPECTED AT TIME OF SERVICE. ANY OTHER ARRANGEMENTS MUST BE MADE IN ADVANCE.

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ M \_\_\_\_ F \_\_\_\_ Mar \_\_\_\_ Sing \_\_\_\_ Wid \_\_\_\_ Div \_\_\_\_ Sep \_\_\_\_  
LAST FIRST INITIAL

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
APT.#

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ E-Mail \_\_\_\_\_  
MONTH DAY YEAR

Employed by \_\_\_\_\_ Address \_\_\_\_\_ Occupation \_\_\_\_\_  
IF SELF-EMPLOYED, NAME OF BUSINESS

Insurance Coverage Yes  No  Emergency Phone: \_\_\_\_\_ Name: \_\_\_\_\_

Patient's SS# \_\_\_\_\_

Closest Relative or Responsible Party \_\_\_\_\_ Relationship \_\_\_\_\_ Address \_\_\_\_\_

Employed by \_\_\_\_\_ Address \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Coverage \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Family Physician \_\_\_\_\_ City \_\_\_\_\_ Date of last visit \_\_\_\_\_

Whom may we thank for referring you to our office?

Name \_\_\_\_\_ Address \_\_\_\_\_

## PODIATRY INFORMATION

Describe your foot complaint \_\_\_\_\_

When did symptoms first appear or accident happen? \_\_\_\_\_

Date of Injury \_\_\_\_\_  Home  Work  Other \_\_\_\_\_

Previous treatment for this condition \_\_\_\_\_

Have you ever had foot or leg surgery  arch support  X-rays  other foot treatment \_\_\_\_\_

Previous Podiatrist \_\_\_\_\_

## HEALTH INFORMATION

1. Are you in good health? Yes \_\_\_\_\_ No \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

2. Are you under physician's care? \_\_\_\_\_ For what? \_\_\_\_\_

3. Are you pregnant? \_\_\_\_\_

4. Medications presently taking regularly \_\_\_\_\_

5. Are you allergic to  novocaine  penicillin  aspirin  antibiotics  adhesive tape  sulfa  Others \_\_\_\_\_

6. Do you have prolonged bleeding?  Yes  No on Blood Thinner? \_\_\_\_\_

7. Have you ever had or been treated for the following:

Heart Trouble  Diabetes  Asthma  Epilepsy  Rheumatic Fever  Nervous disorders

Ulcers  Tuberculosis  Anemia  Arthritis  Low back pain  Leg cramps

Gout  Alcoholism  Artificial joints  High blood pressure  Kidney or liver involvement

AIDS  Other \_\_\_\_\_

8. Have you been hospitalized in the past year?  Yes  No \_\_\_\_\_