PATIENT INFORMATION

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

Today's Date _____

Name _____ (LAST / FIRST / INITIAL) M ___ F ___ Mar ___ Sing ___ Wid ___ Div ___ Sep ___

Address _____ (APT.#) City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Business Phone _____

Age _____ Date of Birth _____ (MONTH / DAY / YEAR) E-Mail _____

Employed by _____ (IF SELF-EMPLOYED, NAME OF BUSINESS) Address _____ Occupation _____

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 _____
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 _____