

Please print all information legibly. Thank you.

Patient Name _____ **Birth Date** _____ **Male** _____ **Female** _____
First M.I. Last

Home Address _____
Street City State Zip

Phones: Home _____ **Cell** _____ **Work** _____

S.S. Number _____ **Driver's License** _____

Employer _____ **Occupation** _____

Employer's Address _____
Street City State Zip

Name of Responsible Party _____ **Relationship to Patient** _____

Home Address _____
Street City State Zip

Phones: Home _____ **Cell** _____ **Work** _____

S.S. Number _____ **Driver's License** _____

Employer _____ **Occupation** _____

Employer's Address _____
Street City State Zip

Emergency Contact _____ **Relationship to Patient** _____

Address _____ **Phone** _____

Do you have a Primary Care Physician? Yes _____ No _____

Physician's Name _____ **Phone** _____

How did you find us? Doctor Referral Patient Referral Ins. Co. Yellow Pages Saw Our Sign Other _____
(please circle one)

Referring Doctor/Patient Name _____

Pharmacy Name _____ **Phone** _____

AUTHORIZATION AND RELEASE OF INFORMATION

I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to myself, or my child, during the period of such care, to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor, or doctor's group, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient, Responsible Party or Guardian

Date

PATIENT MEDICAL HISTORY

Patient Name _____ Date of Birth _____

Describe your foot problem(s) _____

Have you ever been hospitalized for a serious illness? Yes No

Have you ever had surgery? Yes No

(Women) Are you or is there a chance you might be pregnant? Yes No

Do you have or have you ever had any of the following (please circle all that apply):

- | | | |
|---------------------------------|-------------------------------|---------------------------|
| Arthritis/Rheumatoid | Congestive Heart Failure | Hepatitis/Liver Disease |
| Gout | Angina/Heart Attack | HIV/AIDS |
| Diabetes | Coronary Artery Disease | Depression |
| Thyroid Condition/Goiter | Heart Murmur/Valve Problem | Nervous Condition/Stress |
| Kidney Disease/Urinary Problems | Stroke | Skin Disease |
| Ulcers/GI Problems | High Blood Pressure | Glaucoma/Eye Disease |
| Asthma/Bronchitis/Pneumonia | Vascular Disease | Rubella/Small Pox |
| Emphysema/Lung Disease | Bleeding Problems/Blood Clots | Scarlet/Rheumatic Fever |
| Cancer/Tumors | Blood Disorders | Measles/Mumps/Chicken Pox |
| Epilepsy/Seizures | | |

Any disease, condition or problem not listed _____

Have you ever had a severe/traumatic injury or broken bones? Yes No

If yes, details _____

Name of primary care physician and date of last visit _____

Have you seen a Podiatrist before? Yes No

If yes, what did he/she treat you for? _____

To the best of my knowledge, all of the above answers are true and correct. If I ever have any changes in my health, allergies or medications, I will inform the doctor at my next appointment.

Signature of Patient/Authorized Agent _____

Date _____

For Office Staff Only

Reviewed by Dr. _____

Date _____

Updated:

