PATIENT INFORMATION & HEALTH RECORD

In order to help us render the proper podiatric services to you please complete this form in its entirety. We thank you for your cooperation.

Today's Date _________________________ Social Security Number _____ - ____ - _____

Sex M F Date of Birth ____/___/_____ Home Phone (____) _____ - _____

Email ____________________________________ Cell Phone (____) _____ - _____

Name ____ Marital Status S M W D

Address ____ Apt/Unit # _______________

Town _____________________________ State _____________ Zip ____________

Employer _________________________________ Occupation ___________________________

Employer Address _________________________ Town ____________ State ____ Zip_______

Work Phone (____) _____ - _____ Extension ____________

Spouse's Name ______________ Date of Birth ___/___/____ Home Phone (___) ____ - _____
(or if a child, responsible parent's/guardian's name)

In Case of emergency, contact ____________________________ Phone (____) _____ - _____

Nearest Relative _______________________________________ Phone (____) _____ - _____
(not living with you/significant other)

Family Physician ____

Physician's Address ____________________________________ Phone (____) _____ - _____

INSURANCE INFORMATION

Name of Card Holder ______________________________ Relationship to Patient ___________

Name of Insurance Company ____

Insurance Address _________________________ Town ____________ State ____ Zip_______

Insurance Phone (____) _____ - _____ Employer of Card Holder ________________________

Policy # on Card ____________________________ Group # (if any) ______________________
(Include any prefixes ex - "XWG", "R", "C", without them, your claim will be rejected by your Ins. Co.)

DOB of Card Holder ____/___/_____

SECONDARY INFORMATION

Name of Card Holder ______________________________ Relationship to Patient ___________

Name of Insurance Company ____

Insurance Address _________________________ Town ____________ State ____ Zip_______

Insurance Phone (____) _____ - _____ Employer of Card Holder ________________________

Policy # on Card ____________________________ Group # (if any) ______________________
(Include any prefixes ex - "XWG", "R", "C", without them, your claim will be rejected by your Ins. Co.)

DOB of Card Holder ____/___/_____

Were you referred by (circle one) Friend Physician Phone book Website
(If by a friend, please give us their name. If by phone book or website, let us know which one)

Name of person/ad ____________________________ Other/Not Listed ___________________

Describe Your Foot Problem ____

Have you had previous surgery? Yes / No Type of procedure(s) ____________________

Name of Doctor Who Performed Surgery ________________________________

Date of Surgery (approx.) _____________________________

HEALTH INFORMATION

Height ___________ Weight _________ Age ______

Please check of any of the following for which you have been or are being treated:

______	Arthritis	______	HIV
______	Rheumatic Fever	______	Epilepsy/Seizure
______	Scarlet Fever	______	Asthma
______	Hypertension	______	Emphysema
______	Cardiac Disease/High Cholesterol	______	Glaucoma/Cataracts
______	Peripheral Vascular/Arterial Disease	______	Sexually Transmitted Disease
______	Tuberculosis	______	Renal Disease (Kidney)
______	Gout	______	Polio, Cerebral Palsy, Muscular Dystrophy
______	Cerebral Accident (Stroke)	______	Phlebitis/Thrombosis/Blood Clots
______	Diabetes (Insulin or Pill)	______	Thyroid
______	Liver Disease (Hepatitis)	______	Anemia/Bleeding Disorder

Other (Please State) ____

Allergies: Are you allergic to any of the following? Please circle any that may apply.

Penicillin	Asprin
Novocain/Local Anesthetics	Barbiturates
Iodine/Dyes	Caffeine
Tetracycline	Sulfa Drugs
Codeine	Cortisone
Adhesive Tape	Other ________________________________

Are you taking any medication(s)? Yes / No
If yes, please provide a detailed list below.

____

Are you currently under a doctor's care? Yes / No

Have you had previous surgery or hospitalization for any other conditions? Yes / No
If yes/ please provide approximate dates ____/___/_____ ____/___/_____