

PLEASE PRINT

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Res. Phone: _____ Sex: ___ Male ___ Female Marital Status ___ M ___ S ___ W ___ D
Employed by: _____ Work Phone: _____ Occupation: _____
Address: _____
Social Security Number: _____ Driver's License: _____
E-mail Address: _____
Pharmacy Phone: _____ Pharmacy Fax: _____

INSURANCE INFORMATION

Medical Insurance: _____ Group/Policy: _____ ID#: _____
Other Insurance: _____ Group/Policy: _____ ID#: _____
Is this a work related injury? ___ Yes ___ No If Yes, Date of Accident: _____
Claims Adjuster: _____ Phone Number: _____ Insurance Carrier: _____
Address: _____

RESPONSIBLE PARTY (SELF; NAME OF PERSON INSURANCE IS CARRIED BY OR PRIMARY CARRIER OF INSURANCE)

Name of Guarantor (if other than patient) _____ Date of Birth: _____ Age: _____
Employed by: _____ Work Phone: _____ SSN: _____

EMERGENCY CONTACT

Relative or Friend not living with you: _____ Phone Number: _____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?

Name: _____ Address: _____
Internet Yellow Pages (Which Directory?): _____ Other: _____

MEDICAL INFORMATION

Family Doctor: _____ Date of Last Visit: _____
Address: _____ Phone Number: _____
Former Podiatrist/Foot Surgeon: _____
My Foot/Ankle Problem is: Please describe your foot/ankle problem and how long you have had it: _____

1. Are you allergic to any of the following? ___ Local Anesthetic ___ Penicillin ___ Tape ___ Aspirin ___ Iodine ___ Antibiotics ___
Other? _____
2. Do you smoke? ___ Yes ___ No If Yes, how many a day: _____
3. Do you drink Alcohol? ___ Yes ___ No How much per day: _____
4. Are you in good health? ___ Yes ___ No _____

