Last Name:__________________________ First Name:________________ Date:____/____/___

Home Address_________________________ City:__________ St:_________ Zip: _________

Home Phone: _______________________Sex:____ Age: ____ Date of Birth ____/____/______

Employer: _________________________________Business Phone: ______________________

Cell Phone: _________________Email:_______________________ SSN: ____/____/______

Foot Problem: ____

It has troubled me for: Weeks _____ Months ______ Years _____

Insurance Company: ____

Insured's Social security # ____/___/______Insurance under the name of _________________

Spouse's name__________________________

Referred By: ____________________________

Medical and Podiatry information:

Family Doctors Name _______________________________ Last Visit ______________________

Other Podiatrist's Name ____________________________ Last Visit ______________________

Have you ever been treated for the following: **(PLEASE ANSWER YES OR NO TO EACH QUESTION)**

Diabetes____ High Blood pressure ____ High Cholesterol ____ Heart Disease ____ Lung _____

Circulation problems ___ Heart problems ____ Liver_____Asthma ____Stomach ___Kidney___

Depression ___Bleeding Problems ___ Rheumatic fever ____ HIV ___Hepatitis __Epilepsy ____

Arthritis____ Other ____

Do you: Smoke _________ Drink Alcohol __________ Use Drugs _________

Are you allergic to any of the following?

Penicillin ___ Latex ___ Novocain ___ Aspirin __ Iodine ___Codeine ___ Tape ____Other ___

Have you had surgery in the last TEN years? (if yes, describe ____

____________________________________ ____

List all present prescribed and over the counter medications:

____

____

Family History: Diabetes __________High blood pressure __________ Cholesterol __________

I have answered the above questions to the best of my knowledge. I understand that I AM RESPONSIBLE for any services rendered NOT covered by my medical insurance.

____

Patient's signature