JAY G. LEVINE, DPM

55 Old Nyack Turnpike, Suite 407
Nanuet, NY 10954

PATIENT INFORMATIN FORM

Please Print

Name_____**Male ( ) Female ( ) Date:**_____

Address_____

City_____**State**_____**Zip**_____

Home Phone_____**Work Phone**_____**Cell Phone**_____

Date of Birth_____**Social Security Number**_____

Occupation_____**Employer**_____

Referring/Primary Physician_____**Phone Number**_____

Email Address:_____

GUARDIAN AND EMERGENCY CONTACT

Name_____**Relationship to Patient**_____**Phone Number**_____

INSURANCE INFORMATION

Primary Insurance Co._____**Policy#**_____**Group#**_____

Secondary Insurance Co._____**Policy#**_____**Group#**_____

Name of Insured_____ **Date of Birth:**_____

Smoking Current____ **Never Smoked** _____ **Pharmacy and Phone Number**

Alcohol Current____ **Never Drink** _____ _____

MEDICAL INFORMATION

MEDICAL HISTORY

Anemia	No	Yes
Arthritis	No	Yes
Asthma/Lung Disease	No	Yes
Bleeding Problems	No	Yes
Cancer	No	Yes
Clotting Disorder	No	Yes
Diabetes	No	Yes
Gout	No	Yes
Healing Problems	No	Yes
Heart Trouble	No	Yes
HIV/AIDS	No	Yes
Hypertension	No	Yes
Immune Deficiency	No	Yes
Joint Pain	No	Yes
Kidney Disease	No	Yes
Liver Disease	No	Yes
Lyme Disease	No	Yes
Muscle Weakness	No	Yes
Numbness/Tingling	No	Yes
Organ Transplant	No	Yes
Pregnant/Complications	No	Yes
Seizure Disorder	No	Yes
Stomach Ulcers	No	Yes
Thyroid Disease	No	Yes

- *REASON FOR TODAY'S VISIT_____

_____

Other Conditions Not Listed _____

Have you ever received a Blood Transfusion---No-- Yes ----When_____

CURRENT MEDICATION

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FAMILIY HISTORY

Mother_____
Father_____
Other_____

SURGICAL HISTORY

_____
_____
_____
_____

MEDICATION ALLERGIES

Penicillin-----No-------Yes
Sulfa----------No-------Yes
Aspirin--------No-------Yes
Codeine--------No-------Yes
Iodine---------No-------Yes
Latex----------No-------Yes
Other_____