PT#____________
DATE________________

PATIENT INFORMATION SHEET

Welcome to our office. Please take a few moments to carefully fill out this form. This information will better help us to serve you. Thank you.

LAST NAME:______________________________ FIRST NAME/MI:_____________________
STREET:_____________________________CITY/STATE:__________________ZIP:________
PHONE: (______)______-__________ SOCIAL SECURITY NO:______-_____-______
SEX: M F BIRTHDATE:_______-_______-_______ AGE___________

RESPONSIBLE PARTY (IF OTHER THAN PATIENT): WIFE HUSBAND PARENT OTHER
LAST NAME:_____________________________ FIRST NAME/MI:______________________
STREET:_____________________________ CITY/STATE:_________________ZIP:________
PHONE: (______)______-__________ E-MAIL ___________________________________

EMPLOYER:____
STREET:_____________________________ CITY/STATE:_________________ZIP:________
WORK PHONE: (______)______-__________

HOW DID YOU HEAR ABOUT THIS OFFICE?____
____

PRIMARY INSURANCE INFORMATION: Please Make Copy of Insurance Card
INSURANCE COMPANY:____
POLICY NO:______________________________ GROUP NO:_________________________
STREET:_____________________________ CITY/STATE:_________________ZIP:_______
PHONE: (______)______-__________

SUBSCRIBER (IF OTHER THAN PATIENT):
LAST NAME:______________________________ FIRST NAME/MI:_____________________
STREET:_____________________________ CITY/STATE:_________________ZIP:________
PHONE: (______)______-__________ Date of Birth ___________________________

SECONDARY INSURANCE INFORMATION:
INSURANCE
COMPANY:____
POLICY NO:______________________________ GROUP NO:_________________________
STREET:_____________________________ CITY/STATE:_________________ZIP:______
PHONE: (______)______-__________

SUBSCRIBER (IF OTHER THAN PATIENT):
LAST NAME:______________________________ FIRST NAME/MI:_____________________
STREET:_________________________ CITY/STATE:____________________ZIP:_____
PHONE: (______)______-__________

MEDICAL HISTORY

Name of your family doctor______________________________

Address______________________________

Last seen______________________________

Have you seen a podiatrist before?______________________________

If so, for what?______________________________

What foot problem has caused you to seek treatment at this office?

____

When did this problem begin?______________________________

What treatment, if any, have you tried?______________________________

____

What other medical problems do you have? (diabetes, high blood pressure, heart disease, etc.)______________________________

____

What medications are you presently taking?______________________________

____

What hospitalizations or surgery have you had? (Indicate dates)

____

What allergies do you have?______________________________

Do you smoke?__________Packs per week?______________________________

Are you presently pregnant?______________________________

I authorize the release of medical information necessary to process any claim. I authorize payment of benefits either to myself or to Allan I. Rosenthal D.P.M. as agreed upon at the time of treatment for services rendered.

____

SIGNATURE