MORRIS M. PRIGOFF, D.P.M., F.A.C.F.A.S.
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PATIENT INFORMATION: (*PLEASE PRINT*)

LAST NAME: _____FIRST NAME: _____MIDDLE INITIAL: ____

ADDRESS: _____CITY: _____STATE: ____ ZIP: _____

HOME PHONE: # _____CELL#: _____WORK #: _____

S.S.# ____ - ____ - ____DRIVERS LICENSE #: _____ EMAIL: _____

DATE OF BIRTH: ___/___/____ AGE: ___ MALE / FEMALE STATUS: S – M – D – W

PLACE OF EMPLOYMENT: _____ POSITION/TITLE: _____

EMPLOYER'S ADDRESS: _____STATE: _____YRS. OF SERVICE: ____

SPOUSE'S NAME: _____ HIS/HER EMPLOYER: _____

EMPLOYER'S ADDRESS: _____ WORK PHONE: _____
PRIMARY PHYSICIAN: _____PHYSICIAN PHONE: _____
PRIMARY PHYSICIAN ADDRESS: _____
When was your last visit to your Physician? _____
May we contact your physician about your health? YES ___ NO ___
What's the NAME of your PHARMACY? _____
PHONE# _____

PERSON RESPONSIBLE FOR PAYMENT:
NAME: _____
(if other than above)
RELATIONSHIP TO PATIENT: _____ ADDRESS:_____ ZIP: _____
HOME PHONE NUMBER: _____MOBILE #:_____EMAIL: _____
EMPLOYER: _____POSITION: _____
EMPLOYER'S ADDRESS: _____WORK # _____

INSURANCE/MEDICARE/WORKERS COMPENSATION/WELFARE INFORMATION:

NAME OF INSURANCE COMPANY: _____ INSURED SS#: _____ - ___ -_____
INSURED NAME: _____ GROUP #: _____ POLICY#: _____
DO YOU HAVE SECONDARY INSURANCE? YES _____ NO ____
NAME OF SECONDARY INSURANCE: _____SOCIAL #_____ - ____ - _____
INSURED NAME: _____POLICY #_____GROUP # _____
HOW DID YOU HEAR ABOUT US? _____

MEDICAL INFORMATION: This is important for our records and your health.

Describe foot problem: _____

How long has it been bothering you? DAYS _____ WEEKS _____ YEARS ____
Past Problems with feet and ankles? YES _____ NO _____

Past surgical procedures on your feet and ankles? YES _____ DATES: _____
NO _____

Shoe size: _____ Current body weight: _____ Height : _____

Are you **ALLERGIC** or **SENSITIVE** to:

ANTIBIOTICS?	____	HERBS?	____
PENICILLIN?	____	BETADINE?	____
SULFA DRUGS?	____	IODINE?	____
CORTISONE?	____	TAPE?	____
VITAMINS?	____		

Have you had problems taking aspirin or ibuprofen (ADVIL, MOTRIN)? YES ___NO ____

Have you had any problems with LOCAL ANESTHETICS (NOVACAINE, LIDOCAINE)?
YES ___ NO ___

What medications are you CURRENTLY TAKING?
_____
_____

GENERAL HEALTH INFORMATION:

Do you have DIABETES? YES ___ NO ___ If YES, are you taking INSULIN? YES/NO

Number of YEARS with DIABETES? _____ DOSAGE? _____

List any SERIOUS ILLNESSES?
_____

List all MAJOR SURGERIES?
_____

List all the DATES of Surgeries?

Are you under a PHYSICIAN'S CARE? YES ___ NO ____
If Yes, for what? _____

RELEASE OF INFORMATION:

I HEREBY AUTHORIZE RELEASE OF INFORMATION FOR INSURANCE CLAIM PURPOSES. The information authorized for release may include information which may include a communicable or venereal disease, such as Hepatitis, Syphilis, Gonorrhea, HIV, and AIDS.

YES _____ NO _____ DATE: ___/___/_____ SIGNATURE: _____

CHECK ( ) any of the following if you have or have had a problem with:

( )	**Heart**	**( )**	**Stomach Ulcers**	**( )**	**Tuberculosis**
( )	**Circulation**	**( )**	**Hormones**	**( )**	**Rheumatic Fever**
( )	**Arthritis**	**( )**	**Anemia**	**( )**	**Liver**
( )	**Kidneys**	**( )**	**Bladder**	**( )**	**Epilepsy**
( )	**Lungs**	**( )**	**High Blood Pressure**	**( )**	**Weight Loss**
( )	**Cancer**	**( )**	**Skin/Dermis**	**( )**	**Infections**
( )	**Asthma**	**( )**	**Gout**	**( )**	**Healing**
( )	**Intestines**	**( )**	**Neurological Disorder**		

Do you have any artificial JOINTS? YES _____ NO _____
HIPS? YES _____ NO _____
KNEES? YES _____ NO _____
OTHER? YES _____ NO _____

Do you have a HEART VALVE IMPLANT? YES _____ NO _____

FAMILY HISTORY:

MOTHER:	LIVING _____	DECEASED _____	CAUSE OF DEATH:_____
FATHER:	LIVING _____	DECEASED _____	CAUSE OF DEATH:_____
BROTHER:	LIVING _____	DECEASED _____	CAUSE OF DEATH:_____
SISTER:	LIVING _____	DECEASED _____	CAUSE OF DEATH:_____

IS THERE A FAMILY (BLOOD RELATIVE) HISTORY OF:

( )	**HEART DISEASE**	**( )**	**BUNIONS**
( )	**ARTHRITIS**	**( )**	**HAMMERTOES**
( )	**BLEEDING DISORDER**	**( )**	**FLAT FEET**
( )	**NEUROLOGICAL DISORDER**	**( )**	**CIRCULATION PROBLEMS**
( )	**STROKE**	**( )**	**GOUT, ASTHMA, ULCER, EPILEPSY**

Do you smoke? YES _____ (# of Packs? ____) NO _____
Did you previously smoke? YES _____(# of Packs? _____) NO _____
Do you drink alcohol or beer? YES _____ NO _____

(IF YES: Light Usage (1-2x/week) _____
Moderate (1-2x/day) _____
Heavy (+2 daily) _____

Employment: ( ) Sits at Job ( ) Stands at Job ( ) Stands & Walks ( ) Retired

PHYSICIAN RELEASE AND ASSIGNMENT

I, _____, HEREBY AUTHORIZE PAYMENT TO MORRIS M. PRIGOFF D.P.M./CHRIS BOWERS, D.P.M., OF BENEFITS DUE IN MY BEHALF FROM MY INSURANCE. I FURTHER AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION REQUIRED BY MY INSURANCE CARRIER(S). A COPY OF THE AUTHORIZATION MAY BE USED IN LIEU OF THE ORIGINAL SIGNATURE. I REALIZE THAT I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION.

WITH THIS SAME SIGNATURE I AUTHORIZE DR. PRIGOFF/DR. BOWERS TO TREAT ME OR MY CHILD.

_____ DATE: _____

Signature of Parent or Legal Guardian

"The best medical service is based on a friendly, mutual understanding between doctor and patient. We invite you to discuss any of your concerns with us today and let us work together to help you."

~Dr. Prigoff & Dr. Bowers