

**FAMILY PODIATRY
PODIATRY AND FOOT SURGERY**

WELCOME TO OUR OFFICE

PATIENT NAME _____ SEX M F AGE _____ BIRTHDATE _____
HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ CELL PHONE _____ SOCIAL SECURITY # _____
EMPLOYER _____ WORK PHONE _____ E-MAIL _____ MARITAL STATUS S M O
EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____ SUBSCRIBER NUMBER _____ GROUP NUMBER _____
MEDICARE # _____ MEDICARE SUPPLEMENT _____ GROUP NUMBER _____

SUBSCRIBER INFORMATION (IF OTHER THAN PATIENT)

SUBSCRIBER NAME _____ SPOUSE / PARENT BIRTHDATE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
EMPLOYER _____ ADDRESS _____ PHONE _____
SECONDARY (IF HAVE ONE) SUBSCRIBER NUMBER _____ GROUP NUMBER _____
INSURANCE COMPANY _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

MEDICAL AND PODIATRY INFORMATION

FAMILY DOCTOR _____ DATE OF LAST VISIT _____
PREVIOUS PODIATRIST _____ DATE OF LAST VISIT _____

Are you in general good health? Yes / No List any serious illness or surgery you have had and approximate dates _____

List foot surgeries you have had and approximate date _____

Are you allergic to any of the following? (please circle)

Latex / Metals / Tape / Novacaine / Penicillin / Sulfa / Codeine / Other _____

Have you ever been treated for? (please circle)

Diabetes / Heart Problems / Asthma / Epilepsy / Kidney Problems / Liver Problems / Arthritis / Cancer / Stroke
Peripheral Vascular Disease / Autoimmune Disorder / Other _____

Do you have any problem with excessive bleeding when you get cut or delayed healing or clotting? Yes / No

What medications do you take regularly? (If you carry a list with you we will make a copy of it) _____

Height _____ Weight _____ Shoe Size _____ Width _____

BRIEFLY, TELL US WHY YOU CAME TO SEE THE DOCTOR TODAY: _____

I authorize the release of medical information necessary to process any claim. I authorize payment of benefits either to myself or to Family Podiatry as agreed upon at the time of treatment for services rendered.

Patient Signature (or authorized representative) _____ Date _____