Patient Information

(Confidential Information — Important for Our Files and Your Health)

Patient | Date of Birth

Home Address | Telephone

City | State | Zip Code

E-mail | Cell Phone

Patient Employed by | Occupation

Business Address

Business Telephone | Social Security No.

Name of Spouse

Spouse Employed by | Business Telephone

Business Address

Do you have medical insurance? | Are you the insured? | Or a dependent?

Whom may we thank for referring you to this office?

Name | Address

Medical History

Family Physician

Has he/she requested you be seen in our office?

Former Podiatrist

Why did you see your former podiatrist?

1. What problem brings you to this office?

2. Please list all the medicines which you now use:

3. FOR WOMEN ONLY: Are you pregnant? | If so, how many months?

4. Indicate which of your immediate relatives have had any of the following diseases:

Cancer	Diabetes
Heart Trouble	High Blood Pressure
Kidney Trouble	Mental/Emotional Disease
Stroke	Arthritis

5. Please check "Yes" or "No" to indicate if you have had any of the following problems:

Yes	**No**	**Nature of Problem**	**Comments and Give Approximate Date**
		Recent Weight Loss	
		Headaches	
		Trouble with Vision	
		Trouble with Hearing	
		Allergies/Hay fever	
		Asthma	
		Allergic Reaction to Medications	
		Thyroid	
		Diabetes	
		Skin	
		Anemia	
		Heart	
		Mitral Valve Prolapse/Heart Murmur	
		Circulation	
		High Blood Pressure	
		Chest Pain	
		Lungs (Pneumonia, TB, etc.)	
		Shortness of Breath (Cough, Pleurisy, Wheezing)	
		Liver Disease, Gall Bladder Disease (or Jaundice)	
		Stomach Trouble	
		Swelling in Feet or Ankles	
		Arthritis	
		Kidney Disease or Stones	

Yes	No	Nature of Problem	Comments and Give Approximate Date
		Gout	
		Bleeding Tendency	
		Scarring Tendency	
		Joint Pain or Stiffness	
		Numbness in Feet or Legs	
		Cramps in Feet or Legs	
		Low Back Pain	
		Do you smoke?	How much?
		Do you drink alcohol?	How much?
		Do you take any drugs? (legal or illegal)	How much?
		Psychiatric	
		Fainting or Convulsions	
		Strokes	
		Pain in Other Areas	
		Other Illnesses or Problems	
		HIV Positive	

6. Please give details of any:

Operations/Serious Injuries	Approximate Date	Physician	Hospital

7. Have you previously had physical therapy? When? Where? For what condition? ______________________

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8. Is there anything you wish to tell your physician privately? Yes No

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Patient Signature ______________________ Date ______________________

Witness ______________________ Date ______________________

Insurance Information

Primary Insurance Company

Name

Ins. Co. Address

Policyholder's Name

Relationship to Patient

Employer Name

Address

Policy # Group Claim #

Policyholder Sex: F M Birth date

Co-pay $ Deductible $ Verified

Secondary Insurance Company

Name

Ins. Co. Address

Policyholder's Name

Relationship to Patient

Employer Name

Address

Policy # Group Claim #

Policyholder Sex: F M Birth date

Co-pay $ Deductible $ Verified

Lifetime Insurance Authorization to Release Information

I hereby authorize this physician/clinic to release any information, for insurance purposes, required in the course of my examination or treatment, which shall include HIV, Communicable disease or drug abuse information.

Signed: (Patient or Parent, if minor): Date

Authorization to Pay

I hereby authorize payment directly to the business office of this physician/clinic for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the changes not covered by my insurance.

Signed: (Patient or Parent, if minor): Date