NAME	DOB	AGI	ESI	HOE SIZE
HOME PHONE	CELL PHONE	1		-
PHARMACY AND PHONE				
PRIMARY CARE DR AND PHONE		,	- 1	
MEDICATIONS CURRENTLY TAKING	"		,	



We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

## **Patient Information**

Name Last Name First Name	Soc. Sec.#	
Last Name First Name Address	Initial	
City	StateZip	Home Phone
Cell Phone	Email	
Sex M F Age Birth Date Patient employed by	Single Married Occupation	Widowed Separated Divorced
Business Address		
Business Phone	Business Email	
Notify in case of emergency	Home Phone	Work Phone
Cell Phone	Email	
Whom may we thank for referring you?		
Dri	mary Insurance	
	mary mourance	
Person Responsible for Account	First Name	Initial
Relation to Patient		oc. Sec.#
Address (if different from patient)		
City		
Cell Phone		
Person Responsible employed by		ccupation
Business Address		
Business Phone	Business Email	
Insurance Company		
Phone	Email	
Contract #	Group #	Subscriber #
Name of other dependents under this plan		
Add	itional Insurance	
Is patient covered by additional insurance? Yes \( \simeg \)	lo	
Subscriber Name	Relation to Patient	Birth Date
Address (if different from patient)	City	State Zip
Soc. Sec. # Home Phone	Cell Phone	Email
Subscriber Employed by	Business Phone	Business Email
Insurance Company	Phone	
Contract #	Group #	
Name of other dependents under this plan		
realite of other dependents under this plan		

Please complete both sides.

that is the nature of your foot problem?    leight		Patient I	<b>Podiatric</b>	and Health Informati	on
that is the nature of your foot problem?    leight	Family Physician				
Regist	Last Visit				
re your feet lired at the end of the day?   Y   N   Do you have lower back pain?   Y   N   N   Have you had previous foot/ankle surgery?   Y   N   N   Have you had previous foot/ankle surgery?   Y   N   N   If yes, what amount daily?   Y   N   If yes, what amount daily?	What is the nature of your	foot problem?			
re your feet lired at the end of the day?   Y   N   Do you have lower back pain?   Y   N   N   Have you had previous foot/ankle surgery?   Y   N   N   Have you had previous foot/ankle surgery?   Y   N   N   If yes, what amount daily?   Y   N   If yes, what amount daily?	Height		Weight	Shoe S	ize
Medical History  Medica					
Medical History  Medica	Are your feet tired at the e	nd of the day?	Пу Пи	Do you have lower back pain	2
Medical History    Medical History   Medical Hi					
Medical History    Check ( ✓ ) if you have had any of the following:   Arthritis, Rheumatism					
Authorization  Author	Jo you use tobacco produ	CIS (		ii yes, what amount daily?	
Authorization  Author					
Authorization  Author			Media	cal History	
Arthritis, Rheumatism   Cramps/Numbness in feet or legs   Heart trouble   Liver trouble   Ashma   Diabetes   High blood pressure   Swelling of feet or ankles   Bleeding disorder   Eye trouble   Kidney trouble   Varicose veins    are you allergic/sensitive to:   Anesthetics   Materials   Tape   Other    Foods   Penicillin    List medications you are currently taking, if any:  Authorization  have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be use the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor. authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendere authorize the use of this signature on all insurance submissions. authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for lackness the submission of the payment of benefits. I understand that I am financially responsible for lackness the payment of benefits. I understand that I am financially responsible for lackness the payment of benefits.	Check ( ✓ ) if you have ha	d any of the following:			
Authorization  Author			ess in feet or leg	B Heart trouble	Liver trouble
Anesthetics   Materials   Tape   Drugs   Novocaine   Other   Foods   Penicillin    List medications you are currently taking, if any:    Authorization	Asthma		10.00		
Authorization  Author	Bleeding disorder	Eye trouble		Kidney trouble	☐ Varicose veins
Authorization  List medications you are currently taking, if any:  Authorization  have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be use the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor. authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendere authorize the use of this signature on all insurance submissions.  authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for ill charges whether or not paid by insurance.	Are you allergic/sensitive t	o:			
List medications you are currently taking, if any:  Authorization  have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be use the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor. authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendere authorize the use of this signature on all insurance submissions.  authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for a charges whether or not paid by insurance.	Anesthetics				
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authorize the use of this signature on all insurance submissions.  authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for the language of the control of the	have reviewed the information the doctor to help determined the control of the co	ation on this questionnaire mine appropriate treatmen	and it is accurat it. If there is any	e to the best of my knowledge. I un change in my medical status, I wi	nderstand that this information will be us Il inform the doctor.
Il charges whether or not paid by insurance.	authorize my insurance of authorize the use of this	company to pay to the doct signature on all insurance	tor or medical gr submissions.	roup all insurance benefits otherw	ise payable to me for services rendered
ignature Date			ssary to secure	the payment of benefits. I unders	tand that I am financially responsible for
	Signature				Date