

Patient's Name _____ Home Phone _____
 (Please print)
 Address _____ City _____ ZIP _____

Birth Date _____ Age _____ Male Female Social Sec. # _____

Employer _____ Business Phone _____ Cell Phone _____

E-mail Address _____

MEDICAL INSURANCE INFORMATION

Check if Not Insured _____
 Primary Insurance Co. _____ Name of Insured _____
 Insured's Social Sec. # _____ Insured's Date of Birth _____
 Patient's Relationship to Insured: Self Spouse Child Other
 Insured's Employer _____ Secondary Insurance Co. _____

MEDICAL HISTORY

Reason for seeing doctor today _____

 Previous foot, ankle or leg problems / injury / surgery _____

 List Any Other Operations & Dates _____

Do You Smoke? No Yes _____ Pack/day

Have you ever had or been treated for the following?

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Gout | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Bleeding Tendencies |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> AIDS or Related Complex |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Other _____ |

Current Medications _____

Are you allergic to any medications? No Yes (please specify below)
 Penicillin Codeine Cortisone Anesthetics / Novocain
 Vicodin Demerol Aspirin Iodine / Betadine Other _____

Any Other Pertinent Medical / Familial History or Information? _____

Primary Care Physician _____
 Address _____ City _____ ZIP _____

REFERRED BY: _____
 Doctor _____ Address _____ City _____ ZIP _____
 Patient or Friend (please list) _____
 Preferred Provider (PPO) Directory Physician Referral Service S.J.H
 Phone Book / Yellow Pages Internet
 Amateur Athlete Magazine Other (please list)

Signature _____ Date _____