

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)

- |                                      |                                  |                                    |   |
|--------------------------------------|----------------------------------|------------------------------------|---|
| <input type="checkbox"/> Penicillin  | <input type="checkbox"/> Codeine | <input type="checkbox"/> Cortisone | <input type="checkbox"/> Anesthetics / Novocain |
| <input type="checkbox"/> Vicodin     | <input type="checkbox"/> Demerol | <input type="checkbox"/> Aspirin   | <input type="checkbox"/> Iodine / Betadine      |
| <input type="checkbox"/> 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/NMH

Phone Book/Yellow Pages/Dex  Internet (please specify)  Google  Yahoo  Bing  Facebook

Walk by  Other (please list)

Signature \_\_\_\_\_ Date \_\_\_\_\_