

NEW PATIENT INFORMATION SHEET

LAST NAME _____ FIRST NAME _____

STREET _____ CITY _____ STATE _____

ZIP CODE _____ HOME NUMBER _____

BIRTHDAY _____ SEX M F SOCIAL SECURITY # _____

EMPLOYER _____ WORK NUMBER _____

FAMILY DOCTOR _____ DATE LAST SEEN _____

FORMER PODIATRIST _____ DATE LAST SEEN _____

WHO REFERRED YOU TO THIS OFFICE _____

HAVE YOU HAD ANY OF THE FOLLOWING?

YES NO

() () Cramps and numbness in legs/feet

() () Swelling in feet or ankles

() () High Blood Pressure

() () Heart Disease

() () Diabetes

() () Asthma

() () Kidney Disease

() () Vision/Eye Trouble

() () Fractures/Broken bones

() () Ulcers (peptic/duodenal)

YES NO

() () Liver Disease

() () Rheumatic Fever

() () Varicose Veins

() () Arthritis

() () Anemia

() () Hearing Difficulty

() () Blood Disease

() () Low Back Pain

() () Do you smoke?

() () HIV +/- AIDS

Do you have a **Family History** of any of the above illnesses?

Do you have any allergies? If yes please list them:

Are you currently taking any medications?

Name of Medicine Dosage Reason for taking this medicine

Have you been hospitalized for any reason in the last 10 years?

Name of Hospital Date Reason for hospitalization

What is the nature of your complaint?

When did it start? _____

DPM initial _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT) WIFE HUSBAND PATENT OTHER
LAST NAME _____ FIRST NAME/ MI _____
STREET _____ CITY _____ STATE _____
ZIP CODE _____ HOME AND WORK NUMBER _____
DATE OF BIRTH _____

PRIMARY INSURANCE HOLDER'S NAME _____
STREET _____ CITY _____ STATE _____
ZIP CODE _____ PHONE NUMBER _____
DATE OF BIRTH _____

PRIMARY INSURANCE COMPANY
INSURANCE NAME _____
POLICY # _____ GROUP # _____

SECONDARY INSURANCE COMPANY
INSURANCE NAME _____
POLICY # _____ GROUP # _____
SUBSCRIBERS NAME IF OTHER THAN PATIENT _____
STREET _____ CITY _____ STATE _____
ZIP CODE _____ PHONE NUMBER _____
DATE OF BIRTH _____

I understand that failure to provide all pertinent patient information can lead to denial of my claim; therefore I will be held 100% responsible for the visit.

Please make sure that you have a referral if needed by your primary care doctor.

I understand that failure in bringing the necessary referral will hold me 100% responsible for the services rendered. If you wish to make payment, you may do so by cash, check or credit card.

SIGNATURE _____ DATE _____