Welcome To Our Office!

Last Name	First	Middle Initial	Height	Weight	Shoe Size

City	Address	State	Zip	Age	Birth Date

Home Phone Number	Social Security Number	Pharmacy Name & Phone Number

Sex ☐M ☐F	Marital Status Single ☐ Married☐ Widowed☐ Divorced☐	Patient's Employer/Business	Work Number

E-Mail Address: Cell Phone Number:

If married, spouse's name	Spouse's Employer/Business	Work Number	Are there any legal documents with special guidelines or instructions for patient? ☐ Yes ☐ No

If applicable, name of parent(s)/guardian(s)/caregiver(s)	Address	Telephone Number
1.	1.	1. (H) (W)
2.	2.	2. (H) (W)

Check appropriate box and name your referral source
☐ Doctor (name) _____ ☐ Health Fair ☐ Other) _____
☐Another Patient _____ ☐ Yellow Pages

Person to contact in case of emergency	Relationship	Telephone Number
Name of nearest relative not living with you	Address	Telephone Number
Name of nearest relative not living with you	Address	Telephone Number

INSURANCE INFORMATION

Name and address of person responsible for this account	Birth date	Do you have medical insurance? ☐ Yes ☐ No	Is this through your employer? ☐ Yes ☐ No Is this through your spouse? ☐ Yes ☐ No

Primary Insurance	Policy Holder	Policy Holder's Birth date	Policy ID Number	Group Number

Is there secondary insurance (spouse, etc.?)
☐ Yes ☐ No

Secondary Insurance	Policy Holder	Policy Holder's Birth date	Policy/ID Number	Group Number

I hereby give my permission to East Berlin Foot and Ankle Center to administer treatment and to perform such minor Procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and leg condition.

I understand and agree that, regardless of my insurance status, I will be held responsible for the balance on my account and responsible for any services deemed not covered by the insurance company since my insurance coverage is a contract between myself and my insurance company. I have read all the information on both sides of this sheet and have completed all the above questions.

I certify this information is true and correct to the best of my knowledge and will notify you of any changes.

PATIENT SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

Thank You!

Name of Family Physician	Address	Phone	Approximate date of last visit
Are you currently under your physician's care? ☐ Yes ☐ No	If yes, list here	Last blood sugar reading	Do you smoke? ☐ Yes ☐ No How much?
List any medical conditions you have (special conditions, impairments, etc.)			
Have you had previous treatment by a Podiatrist? ☐ Yes ☐ No	When:	For what:	
List any previous surgeries			
My chief foot complaint is:			
This condition(s) has existed for how long:			
What medications/vitamins do you take regularly? Dosages?			

Do you have or have you had any of the following:	Yes	No
Foot or Leg Injuries ……	☐	☐
Foot or Leg Surgeries …….	☐	☐
Foot or Leg Cramps ……	☐	☐
Foot or Leg Numbness ……	☐	☐
Knee Pain ……	☐	☐
Unequal Leg Length ….....	☐	☐

Are you allergic to or sensitive to:	Yes	No
Novacaine ……...	☐	☐
Penicillin …….	☐	☐
Adhesive Tape ……	☐	☐
Materials …….	☐	☐
Drugs ……...	☐	☐
Foods ……...	☐	☐
Anesthetics ……..	☐	☐
Other ……	☐	☐

Do you have or have you had any of the following:	Yes	No
Anemia ……..	☐	☐
Arthritis …….	☐	☐
Bleeder ……..	☐	☐
Blood Disease ……	☐	☐
Breathing Problems (i.e., Asthsma) ……..	☐	☐
Bursitis ……..	☐	☐
Cancer ……...	☐	☐
Circulation Problems …….	☐	☐
Diabetes …….	☐	☐
Epilepsy ……	☐	☐
Fainting Spells ……...	☐	☐
Gout ……	☐	☐
Hardening of the Arteries ……...	☐	☐
Heart Trouble …….	☐	☐
Hepatitis …….	☐	☐
High Blood Pressure ……..	☐	☐
HIV (Human Immunodeficiency Virus) ……	☐	☐
Kidney Disease ……..	☐	☐
Liver Disease …….	☐	☐
Mitral Valve Prolapse …….	☐	☐
Phlebitis ……..	☐	☐
Prone to Infection ……	☐	☐
Rheumatic Fever …….	☐	☐
Stomach Ulcers ……...	☐	☐
Varicose Veins ……		