

PATIENT INFORMATION FORM

WELCOME TO OUR OFFICE. PLEASE TAKE A FEW MOMENTS TO CAREFULLY FILL OUT THIS FORM. THIS INFORMATION IS CONFIDENTIAL AND IMPORTANT FOR OUR FILES AND YOUR HEALTH.

NAME _____ HOME ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
HOME TELEPHONE _____ WORK TELEPHONE _____ EXT _____
DATE OF BIRTH _____ AGE _____ SOCIAL SECURITY # _____
PLACE OF EMPLOYMENT _____
EMPLOYMENT ADDRESS _____
OCCUPATION _____
MARITAL STATUS: SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED _____ SEPARATED _____
NAME OF SPOUSE _____
SPOUSE PLACE OF EMPLOYMENT _____
TELEPHONE NUMBER _____
NAME OF PARENTS (if minor) _____
PARENTS EMPLOYED BY (MOTHER) _____
(FATHER) _____
NAME OF PERSON INSURANCE IS UNDER _____ BIRTH DATE _____
ADDRESS _____ SOCIAL SECURITY # _____
PERSON RESPONSIBLE FOR BILL _____
ADDRESS _____
PRIMARY INSURANCE COMPANY _____
POLICY NUMBER _____ GROUP NUMBER _____
SECONDARY INSURANCE _____
POLICY NUMBER _____ GROUP NUMBER _____
PLEASE NOTE SECONDARY INSURANCE WILL ATTEMPTED TO BE BILLED ONLY ONCE
PLEASE LEAVE YOUR INSURANCE CARDS OUT FOR US TO PHOTO COPY THEM
PERSON TO NOTIFY IN CASE OF EMERGENCY _____
TELEPHONE _____

MEDICAL HISTORY

Name of your family Doctor _____
Address _____ Telephone _____
Has He/She Requested you be seen in Our Office? _____
Date of last complete physical exam _____
Date of most recent blood work _____ Chest x-ray _____ EKG _____
Have you seen a Podiatrist before? _____ If so, for what? _____
Last visit _____
State in your own words, your Medical reason (s) for coming to our office _____
When did the problem begin? _____
What degree of discomfort are you experiencing? _____
How would you describe the discomfort? _____
When does the discomfort occur? _____
What treatment, if any, have you tried? _____
What type of shoegear do you wear most often? _____
Do any of your immediate relatives have problems with their feet? _____
If so, please explain _____
For Women only: are you pregnant? _____ If so, how many months? _____

Have You Ever Had Any of the Following Medical Problems.

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Ulcer or Other GI Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Nervous Condition/Depression |
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Disease/Heart Attack | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Asthma, Emphysema, or Other
Pulmonary Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver or Gall Bladder Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney Disease or Stones |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Thyroid Problems | |

What Medications, If Any, Are You Presently Taking?

Name	Dosage	Name	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are You Allergic To Any Of The Following? (Please Check)

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Adhesive Tape |
| <input type="checkbox"/> Novocaine | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Other _____ |

Family History: Please Indicate Which of Your Relatives Have Had Any of the Following Diseases:

- | | |
|------------------------|-----------------------------------|
| Cancer _____ | Diabetes _____ |
| Heart Trouble _____ | High Blood Pressure _____ |
| Kidney Disease _____ | Mental or Emotional Disease _____ |
| Strokes _____ | Tuberculosis _____ |
| Arthritis _____ | Bleeding Disorders _____ |
| Poor Circulation _____ | |

Please Inform Us of Any Other Important Information _____

Do You Smoke? _____ # of Packs Per Day? _____ # of Years Smoked? _____

Have You Ever Had a Problem With Alcohol? _____

Drug Abuse? _____ If So, Explain _____

Please Give Details Of Any Hospitalizations/Sugeries You Have Had.

Operations	Approx. Date	Surgeon	Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do You Engage In Any Athletic Activity On A Regular Basis? _____

If So, Please Explain _____

I HAVE READ THE ABOVE QUESTIONS AND ANSWERED THEM TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE DR PATTAVINA AND HIS ASSOCIATE(S) TO EXAMINE ME. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO PROCESS THIS CLAIM.

SIGNATURE

DATE

DOCTOR USE ONLY: Ht. _____ Wt. _____ B.P. _____ Temp _____

ptinfo, 1994