

**WELCOME TO OUR OFFICE**

NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_  
LAST FIRST M.I.

SOCIAL SECURITY # \_\_\_\_\_ MARITAL STATUS S M W D

ADDRESS \_\_\_\_\_ TOWN \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_ WORK PHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

SPOUSE OR NEXT OF KIN \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? \_\_\_\_\_

\*\*\*\*\***MEDICAL INFORMATION**\*\*\*\*\*

REASON FOR TODAY'S VISIT \_\_\_\_\_

THIS CONDITION/PROBLEM HAS EXISTED FOR \_\_\_\_\_ DAYS \_\_\_\_\_ WEEKS \_\_\_\_\_ MONTHS \_\_\_\_\_ YEARS

PREVIOUS TREATMENT FOR THIS PROBLEM \_\_\_\_\_

HAVE YOU EVER BEEN TO A PODIATRIST?  YES  NO WHEN \_\_\_\_\_ REASON \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ LAST VISIT \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE # \_\_\_\_\_

PHARMACY \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE# \_\_\_\_\_

ARE YOU PRESENTLY BEING TREATED FOR ANY MEDICAL PROBLEMS? (PLEASE DESCRIBE) \_\_\_\_\_

MEDICATIONS (TAKING PRESENTLY) \_\_\_\_\_

PLEASE CHECK IF YOU HAVE BEEN TREATED FOR ANY OF THE FOLLOWING:

- |  |  |   |                                 |
|--|--|---|---------------------------------|
| <input type="checkbox"/> DIABETIC:( last BS _____ HbA1c _____) | <input type="checkbox"/> GOUT            | <input type="checkbox"/> GI. ULCERS           | <input type="checkbox"/> POLIO  |
| <input type="checkbox"/> HEART PROBLEMS                        | <input type="checkbox"/> ARTHRITIS       | <input type="checkbox"/> ASTHMA               | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> HIGH BLOOD PRESSURE                   | <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> LOW BACK PAIN        | <input type="checkbox"/> OTHER  |
| <input type="checkbox"/> SEIZURES                              | <input type="checkbox"/> ANEMIA          | <input type="checkbox"/> CANCER (TYPE: _____) |                                 |
| <input type="checkbox"/> PHLEBITIS                             | <input type="checkbox"/> KIDNEY PROBLEMS | <input type="checkbox"/> BLEEDING PROBLEMS    |                                 |
| <input type="checkbox"/> POOR CIRCULATION                      | <input type="checkbox"/> HEPATITIS       | <input type="checkbox"/> HIV/AIDS             |                                 |

ALLERGIES (PLEASE CHECK IF APPLY):

- |  |  |                                  |
|--|--|----------------------------------|
| <input type="checkbox"/> LOCAL ANESTHESIA  | <input type="checkbox"/> CODEINE         | <input type="checkbox"/> ASPIRIN |
| <input type="checkbox"/> PENICILLIN        | <input type="checkbox"/> CORTISONE       | <input type="checkbox"/> SEAFOOD |
| <input type="checkbox"/> SULFA DRUGS       | <input type="checkbox"/> IODINE/BETADINE | OTHERS _____                     |
| <input type="checkbox"/> OTHER ANTIBIOTICS | <input type="checkbox"/> ADHESIVE TAPE   | _____                            |

LIST ANY OPERATIONS OR INJURIES: \_\_\_\_\_

Is there a Family Medical History of: Diabetes YES/NO Heart Disease YES/NO Cancer YES/NO (type: \_\_\_\_\_)

DO YOU SMOKE? YES / NO How many/day? \_\_\_\_\_ How many years? \_\_\_\_\_

ARE YOU A FORMER SMOKER? YES / NO Are you exposed to second hand smoke? YES / NO

DO YOU USE SMOKELESS TOBACCO? YES / NO

DO YOU DRINK ALCOHOL? YES / NO Frequency \_\_\_\_\_

DO YOU CONSUME CAFFEINE? YES / NO Frequency \_\_\_\_\_

Initial \_\_\_\_\_

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**NEW GOVERNMENT REQUIRED INFORMATION:**

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

Race: Asian Black Hispanic White Other- \_\_\_\_\_ If Hispanic- do you consider yourself Latino? YES / NO

Primary language spoken: \_\_\_\_\_

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**INSURANCE INFORMATION**

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

PRIMARY MEDICAL INSURANCE \_\_\_\_\_  
NAME OF POLICY HOLDER \_\_\_\_\_ THEIR DATE OF BIRTH \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_ SS# \_\_\_\_\_  
POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_  
IS THIS INSURANCE THROUGH EMPLOYER? YES  NO

SECONDARY MEDICAL INSURANCE \_\_\_\_\_  
NAME OF POLICY HOLDER \_\_\_\_\_ THEIR DATE OF BIRTH \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_ SS# \_\_\_\_\_  
POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_  
IS THIS INSURANCE THROUGH EMPLOYER? YES  NO

LIST ANY OTHER MEDICAL INSURANCE COVERAGE: \_\_\_\_\_  
\_\_\_\_\_

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE ON MY BEHALF TO BLACKWOOD-CLEMENTON FOOT AND ANKLE SPECIALISTS / DRS. KLEIN FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN / SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

I UNDERSTAND THAT THE ULTIMATE RESPONSIBILITY FOR PAYMENT OF SERVICES IS BY THE INSURED (CLAIMS ARE FILED AS A COURTESY). THIS INCLUDES PAYMENT OF ANY LATE FEES THAT ACCRUE (AT A RATE OF \$5 PER MONTH) ON OVERDUE ACCOUNTS AS WELL AS REASONABLE ATTORNEY OR COLLECTION FEES IF COLLECTION PROCEEDINGS NEED TO BE INITIATED.

\_\_\_\_\_  
PATIENT'S / GUARDIAN'S SIGNATURE

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I HEREBY GIVE PERMISSION TO THE DOCTORS TO EXAMINE AND TREAT MY PODIATRIC NEEDS AS DEEMED NECESSARY OR ADVISABLE.

PATIENT'S/GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_