

FOOT AND ANKLE SPECIALISTS
BARRY A. KLEIN, DPM, FACFAS, DABPS
DEBRA B. KLEIN, DPM, FACFAS, DABPS

OFFICE LOCATION (Please check one):

Pine Hill _____
Florence _____

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 _____ WORK PHONE _____ CELL PHONE _____ E-MAIL _____

NAME OF EMPLOYER _____ OCCUPATION _____

SPOUSE OR NEXT OF KIN _____ RELATIONSHIP _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? (Fill in all that apply)

DOCTOR'S NAME _____ PATIENT'S NAME _____
BELL YELLOW PAGES _____ INSURANCE BOOK _____
SIGN _____ AD _____ OTHER _____

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 # _____

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:

_____ DIABETES	_____ GOUT	_____ GI. ULCERS	_____ POLIO
_____ HEART PROBLEMS	_____ ARTHRITIS	_____ ASTHMA	_____ STROKE
_____ HIGH BLOOD PRESSURE	_____ RHEUMATIC FEVER	_____ LOW BACK PAIN	_____ OTHER
_____ SEIZURES	_____ ANEMIA	_____ CANCER (TYPE: _____)	
_____ PHLEBITIS	_____ KIDNEY PROBLEMS	_____ BLEEDING PROBLEMS	
_____ POOR CIRCULATION	_____ HEPATITIS	_____ HIV/AIDS	

ALLERGIES (PLEASE CHECK ALL THAT APPLY):

_____ LOCAL ANESTHESIA	_____ CODEINE	_____ PENICILLIN	_____ CORTISONE
_____ SULFA DRUGS	_____ IODINE/BETADINE	LIST OTHERS _____	
_____ OTHER ANTIBIOTICS	_____ ADHESIVE TAPE	_____	
_____ ASPIRIN	_____ SEAFOOD	_____	

LIST ANY OPERATIONS OR INJURIES: _____

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 _____