

Drs. Arthur Weisman and Ryan Frank - Podiatrists

PATIENT INFORMATION
(Confidential Information – Important for Our Files and Your Health)
PLEASE FILL OUT ALL INFORMATION

Patient _____ Date of Birth _____ Age _____

Name you go by _____ Sex: M F Martial Status: S M D W

Home Address _____ Social Security # _____

City, State, Zip _____ Telephone # _____

If Minor, Name of Responsible Party _____

Patient (or Parent) Employed by _____ Occupation _____

Business Address _____ Business Telephone # _____

Name of Spouse _____ Spouse Employed by _____

How did you hear about our office? _____

INSURANCE INFORMATION

Primary Insurance Company _____

Policy # _____ Group # _____

Secondary Insurance Company _____

Policy # _____ Group # _____

Subscriber's Name and Date of Birth _____

MEDICAL HISTORY

Family Physician _____ Telephone # _____

Last visit to your physician? _____

What foot problems bring you to our office? _____

How long has it bothered you? _____

Have you injured your foot? How? _____

Please list any previous foot care/foot surgeries _____

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ADDITIONAL MEDICAL INFORMATION

Height _____ Weight _____

Please list all medicines which you now use _____

Please list medication allergies _____

Please list any operations/serious injuries and give approximate dates _____

FOR WOMEN ONLY

Are you pregnant? _____ If so, how many months? _____

Do you use birth control pills? _____

Person to contact in case of an emergency _____

Telephone # _____

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including private insurance and all other health plans to **Heartland Podiatry, P.C.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNATURE _____ **DATE** _____

PLEASE CHECK "YES" OR "NO" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING

YES	NO	NATURE OF PROBLEM	COMMENTS AND GIVE APPROXIMATE DATE
		Hay fever/Asthma	
		Diabetes	
		Thyroid	
		Gout	
		Skin	
		Anemia	
		Heart Problems	
		Circulation	
		High Blood Pressure	
		Breathing Difficulties	
		Liver Disease	
		Stomach Problems	
		Arthritis	
		Kidney Disease	
		Bleeding Tendency	
		Numbness in Feet or Legs	
		Scarring Tendency	
		Low Back Pain	
		Do you smoke? How much?	
		Do you drink alcohol?	
		How much?	
		Do you use illegal drugs?	
		How much?	
		Psychiatric	
		Fainting or Convulsions	
		Strokes	
		HIV Positive or AIDS	
		Other Conditions not listed	