New Hyde Park Podiatry, PC

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PATIENT INFORMATION

Patient Name:______________________________
Home Address:______________________________
City:____________________ State:______________ Zip:__________
Home Phone:____________________ Cell Phone:____________________
Work Phone:____________________ Email Address:____________________
Date of Birth:____________________ Social Security #:____________________
Sex: M / F Marital Status: S / M / D / W Occupation: ____________________

Emergency Contact:____________________ Phone #: ____________________
Relationship: ____________________

Family Doctor:______________________________
Address:______________________________
City:____________________ State:______________ Zip:__________
Office Phone: ____________________ Office Fax:____________________

Pharmacy Name______________________________
Address:______________________________
City:____________________ State:______________ Zip:__________
Phone #: ____________________

How were you referred to the office? ______________________________

INSURANCE INFORMATION

Primary Insurance Co:____________________ Policy ID#:____________________
Group#:____________________
Policy Holder Name:____________________ Policy Holder Date of Birth:__________
Relationship to Patient:____________________ Policy Holder Sex: M / F
Relationship to Patient: Self / Spouse / Parent / Guardian / Domestic Partner

Secondary Insurance Co:____________________ Policy ID#:____________________
Group#:____________________
Policy Holder Name:____________________ Policy Holder Date of Birth:__________
Relationship to Patient:____________________ Policy Holder Sex: M / F
Relationship to Patient Self / Spouse / Parent / Guardian / Domestic Partner

MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

[ ] Diabetes
[ ] High Blood Pressure
[ ] Heart Disease

[ ] Kidney Disease
[ ] Liver Disease
[ ] Lung Disease
[ ] Epilepsy / Seizures
[ ] Asthma / Emphysema
[ ] Anemia
[ ] Blood Clots / Phlebitis
[ ] Cancer (type:____)
[ ] Gout
[ ] Arthritis (type:____)
[ ] Pregancy
[ ] HIV / AIDS
[ ] Excess Scarring / Keloid Formation
[ ] Other not listed: ____
[ ] Do you smoke? ____________ How many packs per day? ________
[ ] Do you drink alcohol? __________ How many drinks per day? ________
[ ] Do you take Non-Prescription Drugs? _________Type?______________

MEDICAL ALLERGIES

[ ] Penicillin
[ ] Codeine
[ ] Local Anesthesia
[ ] Latex
[ ] Adhesive Tape
[ ] Aspirin
[ ] Others not listed:____

MEDICATIONS (PLEASE LIST ALL CURRENT MEDICATIONS)

____
____
____

SURGERIES (PLEASE LIST ALL)

____
____
____
____

WHAT IS YOUR FOOT PROBLEM/CONCERN AND HOW LONG HAS IT BEEN THERE?

____
____

I certify that the above information that is provided is correct and that my failure to disclose any medical conditions/medications may put me at risk. I give permission to the doctor to administer such procedures that may be necessary in the diagnosis and treatment of my feet:

________________________________ ____________________
Patient or Guardian Name **Date**