

PATIENT INFORMATION

(Please Print)

Mr. / Mrs. / Ms. / Child / Other (Circle one)

Name _____

Home Address _____ City, State, Zip _____

Home Phone (_____) _____ Occupation _____

Social Security # _____ Date of Birth _____

Employer _____ Business Phone (_____) _____

Person Responsible for Payment of Account _____

Referred by (Circle one) Ad / Phone Book / Relative / Friend / Dr. _____

Family Physician _____ Phone _____

Physician Address _____

Briefly describe your main foot complaint _____

Person(s) authorized to receive your health and account information _____

Relationship to Patient _____ Phone (_____) _____

Former Foot Doctor _____ Last Visit _____

Do you Have Medical Insurance? YES NO Insurance Company _____

Policy Holder Name _____ Policy Holder Date of Birth _____

- YES NO** 1. Are you in good health?
- YES NO** 2. Have you been under a physician's care in the past 2 years?
- YES NO** 3. Are you subject to prolonged bleeding?
- YES NO** 4. Do you have diabetes?
- YES NO** 5. Is there family diabetes?
- YES NO** 6. Do you have any allergies to, or have you experienced any ill effects from any medications? If YES, which one(s)? _____
- YES NO** 7. Have you ever been treated for heart trouble, asthma, epilepsy, rheumatic fever, kidney or liver involvement? If YES, which one(s)? _____
- YES NO** 8. Have you had any serious illnesses or operations?

Please list medication(s) you are currently taking: _____

I hereby authorize Dr. Lapow and/or Dr. Sanicola to administer treatment and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition. I also understand that I am ultimately responsible for payment of services and/or treatment rendered to me by Dr. Lapow and/or Dr. Sanicola, **including payment of all co-pays at the time of each visit.**

Date _____ Signature _____