WELCOME TO OUR OFFICE

NAME: _____D.O.B._____

ADDRESS: _____CITY_____

STATE: _____ZIP CODE_____SS#_____

HOME PHONE: _____CELL PHONE:_____

WORK PHONE: _____EMAIL ADDRESS: _____

PREFERRED METHOD OF CONTACT: CIRCLE ONE: PHONE CELL WORK EMAIL

SEX: _____SHOE SIZE: _____HT:_____WT:_____

MARITAL STATUS: S M W D REFERRED BY: _____

WHO CAN WE NOTIFY IN CASE OF EMERGENCY: _____

GENERAL HEALTH INFORMATION

What problem are you having today? _____
Please list all known allergies or sensitivities: _____
_____
Please list all medications you take regularly: _____
_____
_____
Family Physician:_____
Physician Phone:_____
Pharmacy Name and Location:_____
_____

Please circle any of the following that apply to you:

DIABETES: If yes circle (insulin or pills) TUBERCULOIS

ANEMIA HIGH BLOOD PRESSURE LUPUS

STROKE ULCER HIV/ AIDS

GOUT KIDNEY TROUBLE ASTHMA

HEART TROUBLE MULTIPLE SCLEROSIS SKIN DISORDER

GLAUCOMA EPILEPSY NEUROPATHY

THYROID HIGH CHOLESTEROL ARTHRITIS

HEPATITIS LIVER DISORDERS RHEUMATIC FEVER

NEUROLOGICAL CANCER: type_____

ALCOHOL QUANTITY IS: NONE 1-2 PER WEEK
1-2 PER DAY 2 OR MORE PER DAY

TOBACCO QUANITY: NEVER 1 PACK PER DAY 2 PACK PER DAY
QUIT WHEN:_____

ANY PAST FOOT/ANKLE PROBLEMS: YES NO WHEN: _____
WHAT: _____

ANY PAST FOOT/ANKLE SURGERIES: YES NO WHEN: _____
WHAT: _____

DO YOU HAVE ANY ARTIFICIAL JOINT(s) YES NO WHERE: _____
_____

EMPLOYER:_____

SITS SITS AND STANDS STANDS STANDS & WALKS RETIRED UNEMPLOYED

IS YOUR FATHER LIVING? YES NO CAUSE: NATURAL CAUSES
CANCER DIABETES HEART ATTACK STROKE OTHER

IS YOUR MOTHER LIVING? YES NO CAUSE: NATURAL CAUSES
CANCER DIABETES HEART ATTACK STROKE OTHER

WHAT RACE ARE YOU? WHITE AFRICAN AMERICAN ASIAN ARABIC

AMERICAN INDIAN ALASKA NATIVE HAWAIIAN NATIVE HISPANIC

PACIFIC ISLANDER OTHER: _____

INSURANCE AUTHORIZATION

I do hereby grant permission to Dr. David E. Beneson DPM to administer medication and perform procedures as may be deemed necessary in the interest and care of myself. I understand I am responsible for paying any or all balance(s) due for services rendered. I authorize the office to furnish my insurance company (s) with all necessary information regarding my present illness or injury. I also authorize any necessary test, laboratory tests, x-rays, and or HIV/AIDS tests to be performed if the doctor deems necessary. I understand that the office strives to achieve the highest standards of ethics and integrity in performing services and complies with the government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the “Privacy Rule”.

PATIENT: _____

GUARDIAN: _____

DATE: _____