

New Patient Information

Date:	Acct. #	ID #		
Name: _____ <small>(Last) (First) (Middle)</small>				
Address: _____ <small>(Number) (Street) (Apt. #)</small>				

<small>(City) (State) (Zip)</small>				
Home Phone:	Work Phone:	Birth Date:	Sex:	Marital Status:
Employer:		Social Security #:		
Address:		Referred by:		

Financially Responsible Person

Name: _____						Relation to Patient: _____					
Address: _____											
<small>(Number)</small>		<small>(Street)</small>		<small>(Apt. #)</small>		<small>(City)</small>		<small>(State)</small>		<small>(Zip)</small>	
Home Phone:						Work Phone:					
Employer:						Employer's Address:					
Person to Notify in Emergency:								Phone:			

Medical Insurance Coverage

Primary Insurance Company:	ID/Policy #:	Group #:
Insurance Address:		Policy Holder: Date of Birth:
Secondary Insurance Company:	ID/Policy #:	Group #:
Insurance Address:		Policy Holder: Date of Birth:
Other Insurance Company:		
Insurance Address:		Policy Holder: Date of Birth:

Patient Information

I, _____, hereby authorize _____ to apply for benefits
Patient's Name Physician's Name
on my behalf for covered services rendered by _____. I request payment from
_____, _____, and/or _____ be made directly to
Ins. Company #1 Ins. Company #2 Ins. Company #3
_____. (or in the case of Medicare part B benefits, to me or to the party who accepts
Physician's Name
assignment).

I certify that the information I have reported with regard to my insurance coverage is correct and further
authorize the release of any necessary information including medical information for this or any related
claim, to _____, _____ and/or _____ (or in the case of
Ins. Company #1 Ins. Company #2 Ins. Company #3
Medicare part B benefits, to the Social Security Administration).

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked
in writing at anytime by the above carrier or me.

Signature of subscriber or beneficiary

Identification

Date

What is the reason for your visit today? _____

When did your symptoms start? _____

What medical problems do you have or are you being treated for? Please circle all that apply:

Arthritis Diabetes Cancer High Blood Pressure Heart disease High Cholesterol

Bleeding Disorders Anemia Hepatitis Liver Disorders Thyroid Problems

Respiratory Problems Kidney Disorders Stomach or Intestinal Problems Neurological problems

Stroke HIV/AIDS Other _____

Please list any operations you have ever had: _____

Please list all medications you are currently taking including aspirin and vitamins:

Please list any allergies to medications:

Social history: Are you currently a smoker? _____ If so, how much do you smoke? _____

Were you ever a smoker? _____ How much alcohol do you drink? _____

Do you use recreational drugs? _____

Family History: Please list whether anyone in your immediate family has any of the following: Arthritis, Diabetes, Heart disease, Cancer, Bleeding Disorder, Anesthesia Problems, High Blood Pressure, or Other Serious Medical Problems.

CONSENT FOR TREATMENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to Lakeforest Foot and Ankle Center to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient or Guardian

Date