PATIENT INFORMATION

DATE: _____

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____ _____
NUMBER STREET APT. CITY STATE ZIP

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMAIL: _____DATE OF BIRTH: _____ GENDER: _____ MALE _____ FEMALE

MARITAL STATUS: _____ SS# _____-_____-_____

EMPLOYER NAME/ADDRESS:_____ _____

PRIMARY CARE DOCTOR: _____
Name, Address & Phone Number

PREFERRED PHARMACY: _____
Name, Address & Phone Number is **Required**

PRIMARY LANGUAGE: _____ ETHNICITY: _____ HISPANIC OR LATINO _____ NOT HISPANIC OR LATINO

RACE: ____ AMERICAN INDIAN OR ALASKAN NATIVE _____ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
____ ASIAN _____ BLACK OR AFRICAN AMERICAN _____ WHITE

How did you hear about us:_____ Primary Care Doctor _____Internet(Please Circle): Google ,Yahoo, Bing, Yelp or other
_____ Insurance Website/Insurance Carrier _____Friend/Family _____Other:_____

FINANCIALLY RESPONSIBLE PERSON

NAME: _____ RELATION TO PATIENT: _____PHONE: _____

ADDRESS: _____EMAIL: _____

EMPLOYER NAME/ADDRESS: _____

OTHER PERSON TO NOTIFY IN EMERGENCY: _____ PHONE# _____

MEDICAL INSURANCE COVERAGE

NAME OF PRIMARY INS. CO.. _____
ID/POLICY# _____ GROUP# : _____
POLICY HOLDER NAME: _____ D.O.B.: _____
RELATIONSHIP TO HOLDER: _____SELF _____SPOUSE _____GUARDIAN

NAME OF SECONDARY INS. CO. _____
ID/POLICY# _____ GROUP# : _____
POLICY HOLDER NAME: _____ D.O.B. : _____
RELATIONSHIP TO HOLDER: _____SELF _____SPOUSE _____GUARDIAN

I understand and acknowledge that I am personally responsible for the services rendered at this facility. Lakeforest Foot and Ankle Center will bill my insurance as a courtesy. In the event of non-payment, I understand I will be responsible for any outstanding balances.

_____
SIGNATURE OF SUBSCRIBER OR BENEFICIARY DATE

Name:_____ Height: _____Weight: _____ Shoe Size: _____

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:

Alcoholism
Allergies/hayfever
anemia
Anxiety
Asthma
Artial Fibrillation
Blood Transfusions
CAD/Heart Desease
Cancer
Cardiac Pacer
Cardiovascular Disease
Heart Failure/CHF
Cirrhosis
Colitis
COPD
CRF
Crohn's Disease
CVA/Stroke
DVT/Clot
Depression
DM Type 1
DM Type 2
Epilepsy
Fracture
Gastric Ulcer
Gastrointestinal Disease
GERD/Acid Reflux
Gestational Diabetes
Glaucoma
Heart Murmur
Hepatitis
High Cholesterol
Hyperlipidemia
Hypertension
Hyperthyroidism
Hyporthyroidism
Insulin Pump
Joint Pain
Kidney Infections
Kidney Stone
Migraine
Multiple Sclerosis/MS
Obesity
Old MI
Osteoarthritis
Osteoporosis
Pneumonia
Progressive Neurological Disorder
Pulmonary Disease/Lung Problems
Rheumatic Fever
Rheumatoid Arthritis
Sexually Transmitted Disease/STD
Terminal Illness
Thyroid Disease
TIA/Mini-Stroke
Tuberculosis/TB
Vascular Problems

Other Medical History: _____

Please list any operations you have ever had: _____

_____

Please list all medications you are currently taking including **strength**:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Please list any allergies to medications:

Name: _____ Reaction: _____
Name:_____ Reaction: _____
Name: _____ Reaction: _____

Family History(Please Circle):

Alcoholism
Anemia
Anxiety
Asthma
Birth Defects
CAD/Heart Disease
Cardiovascular Disease
CHF/Heart Failure
Cancer:_____
Congenital Anomaly
COPD
Crohn's Disease
Depression
Diabetes
Epilepsy
GERD/Acid Reflux
Hypercholesterolemia
Hyperlipidemia
Hypertension
Hypothyroidism
Kidney Disease
Liver Disease
Multiple Births
Osteoarthritis
Osteoporosis
Pulmonary Disease
Stroke

Smoking Status: _____ Current every day Smoker _____ current some day smoker
_____ former smoker _____ Never Smoker

Alcohol Use: _____ None-Drinker _____ Occasional Drinker _____ Social Drinker
_____ Heavy Drinker _____ Recovery Alcoholic

TOBACCO USE: _____ YES _____NO

Do you frequently experience or have you recently experienced any of the following symptoms? PLEASE CIRCLE:

Weight change (gain or loss)
Fever
Chills
Feeling tired or poorly
Weakness

Rapid or irregular heart beat(palpitations)
Chest pain
Swelling of feet or legs
-Cold hands and feet
-Calf pain while walking

Cough
Wheezing
Difficulty breathing
Shortness of breath

Poor appetite
Light-colored bowel movement
Nausea
Vomiting
Diarrhea
Abdominal pain
Abnormal liver function tests

Arthritis
Back pain
joint pain
Joint Stiffness
-Gout
-Muscle aches
-Muscle cramps

Seizures
Weakness
Numbness
-Tingling sensation
-Burning sensation

Rash
Itching
Dry skin
Cysts or other masses under skin
-Bruising
-Hives
-Flushing
-Skin bump (small or large)

I certify that the above information is true and correct to the best of my knowledge. I give my permission to Drs. Michetti, Tabor and Weber to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

_____ _____

Patient or Guardian Date