PATIENT INFORMATION

Please Print

Name: ______________________________ DOB: __________________ Date: ___________
Address: __________________________________ City: _______________ State: _________
Zip Code: ___________ Email Address: ____
Home Ph: _________________ Work Ph: __________________ Cell Ph: _________________
Sex: M F Age: _______ Height: _________ Weight: _________ Marital Status: S M D W
Drivers License #: _____________________ SS #: _______________________
In case of emergency, contact whom?: ____
Relation: ________________________________ Phone: ______________________________

Medical Information

Yes	No		Yes	No		Yes	No	
❑	❑	Heart Disease	❑	❑	Diabetes	❑	❑	Cholesterol
❑	❑	Arthritis	❑	❑	High Blood Pressure	❑	❑	HIV Positive

Shoe Size: _______ Medication List: ____
____
Drug Allergies: ____
Chief Complaint or Problem: ____
____
Date Symptoms Began / Injury Occurred: ____
Family Physician: _______________________________ Phone #: _____________________
Address: _________________________________ City, State, Zip: ___________________
May we send a copy of your foot evaluation to him/her for your medical records? ❑ Yes ❑ No

Who may we thank for referring you to our office? ____________________________________

About Your Insurance

Primary Insurance: ______________________	Secondary Insurance: ______________________
Ins. Co. Phone #: ______________________	Ins. Co. Phone #: ______________________
Patient Relationship to Insured: Self / Spouse / Child / Other	Patient Relationship to Insured: Self / Spouse / Child / Other
Effective Date of Insurance: ______________________	Effective Date of Insurance: ______________________
Insured's Name: ______________________	Insured's Name: ______________________
Address: ______________________	Address: ______________________
City, State, Zip: ______________________	City, State, Zip: ______________________
Insured's Employer: ______________________	Insured's Employer: ______________________
Insured's Date of Birth: ______________________	Insured's Date of Birth: ______________________
Insured's Phone #: ______________________	Insured's Phone #: ______________________
Policy # / Group ID #: ______________________	Policy # / Group ID #: ______________________
Insured's Social Security #: ______________________	Insured's Social Security #: ______________________

I hereby grant permission to Diagnostic Foot Specialists to examine and treat my feet and/or ankles. I also agree that the above information is true and correct.

Signed: ________________________ **Date:** _____________ **Signature for minor:** ____________________
I authorize the release of any medical information allowed by HIPAA rules and regulations necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignments.

Signed: __________________________________ **Date:** ____________________