CHOICE PODIATRY ASSOCIATES

Dr. Jay Feist, Dr. Jeffrey Fley, Dr. Irvin Lewin, Dr. John Rootring

Patient Information

Legal Name ____________________ Date __________

Address ______________________________

City ____________________ State ________ Zip __________

Phone: Home __________ Cell __________ Work __________

Patient SSN __________ Email Address __________

Date of Birth __________ Age ________ Sex: M / F Status: M / S / D / W

Occupation __________ Employer __________

Spouse s Name ______________________________

How did you hear about us? (Circle all that apply and fill in name, if applicable)

a) Referred by Doctor __________ b) Referred by an existing patient __________

c) Referred by a friend or relative __________ d) Website __________ e) Yellow Pages

f) Other ______________________________

Insurance Information

Primary

Insurance Name __________ ID Number __________ Group # ________

Policy holder name __________ Policy holder DOB __________

Policy holder SSN __________ Policy holder work number __________

Secondary

Same as primary above yes / no

Insurance Name __________ ID Number __________ Group # ________

Policy holder's name __________ Policy holder's DOB __________

Policy holder's SSN __________ Policy holder's work number __________

Nearest relative not living with you to notify in case of an emergency

Name __________ Relationship __________ Phone __________

I request that payment of medical benefits be made on my behalf to Choice Podiatry Associates for any services rendered to me. I authorize the release of any medical information necessary for processing insurance claims. Medicare patients authorize the release of medical or other information to this health care financing administration.

I certify that the medical information I have documented is true and correct to the best of my knowledge. I hereby give permission to my Choice Podiatry Associates podiatric physician to administer treatment, and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my foot condition.

Signature ______________________________ Patient or Guardian Date __________

Medical Information

Name and Phone of Primary Care Doctor: ______________________________

Describe your foot problem: ______________________________

____

Have you had any past problems or surgical procedures on your feet? ______________________________

____

Shoe Size __________ Height __________ Weight __________

Are you allergic or sensitive to any medications? ______________________________

____

Do you have any problems with tape, betadine (iodine), aspirin, ibuprofen, latex, novocaine, or lidocaine? Yes No

If so, which? ______________________________

List Exercise Activities ______________________________

Do you or any blood relatives have (or had) any of the following? (Check all that apply)

	You	Family Member		You	Family Member
Diabetes	____	____	Arthritis	____	____
Thyroid Problems	____	____	Artificial Joints	____	____
Gout	____	____	Back Problems	____	____
Kidney Disease	____	____	Osteoporosis	____	____
Liver Disease	____	____	Bone Fracture	____	____
Asthma	____	____	HIV / AIDS	____	____
Heart Disease	____	____	Hepatitis	____	____
High Blood Pressure	____	____	Venereal Disease	____	____
Poor Circulation	____	____	Tuberculosis	____	____
Phlebitis or Blood Clots	____	____	Scarlet Fever	____	____
Numbness in Feet or Hands	____	____	Rheumatic Fever	____	____
Parkinson's Disease	____	____	Artificial Heart Valve	____	____
Epilepsy	____	____	Psoriasis / Eczema	____	____
Stroke	____	____	Cancer	____	____
Bleeding Disorder	____	____	Stomach Ulcer	____	____
Anemia	____	____	Vision Disorder	____	____

Do you smoke? Yes No How much? __________

Do you drink alcohol? Yes No How much? __________

Do you use recreational drugs? Yes No Which ones? __________

Have you had any serious conditions or major surgeries? Yes No If yes, please explain: ______________________________

____

Do you take Coumadin, Aspirin, Plavix or any other types of blood thinners? Yes No

What other medications are you taking? ____

____

____

Signature ______________________________ Date ______________________________