

PATIENT INFORMATION

WELCOME TO OUR OFFICE

In order that we may serve you to the best of our ability, please complete this form as accurately as possible and return it to the receptionist.

Last Name: _____ First Name: _____ M.I. _____
 Salutation: Mr. Mrs. Ms. Other Gender: Female Male Marital Status: Married Single
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____
 Birth Date: _____ Age: _____ Social Security No.: _____
 Place of Employment: _____
 Employer's Address _____

Who referred you to our office? (PLEASE SPECIFY)
 Name: _____ Phone No. _____
 Doctor Patient Yellow Pages Other

Medical Doctor: _____ Work _____
 In general, for what does this physician treat you? _____
 Date of last visit with this physician: _____

MEDICAL INSURANCE INFORMATION (Of Insured Policyholder only)
Primary Insurance Company
 Group# _____ POLICY/ID# _____
 Policyholder's Last Name _____ First Name _____ MI _____
 Birth Date of Policyholder _____ Patient's Relationship to Policyholder _____
 Policyholder's Employment _____
Secondary Insurance Company
 Group# _____ POLICY/ID# _____
 Policyholder's Last Name _____ First Name _____ MI _____
 Birth Date of Policyholder's _____ Patient's Relationship to Policyholder _____
 Policyholder's Employment _____

I authorize Dr. Robert T. Spalding Jr., DPM or any holder of medical information about me to release to any applicable insurance company named above for this or a related claim. I permit a copy of this authorization to be used in place of the original, & request payment of medical benefits either to myself, or to Dr. Spalding, if assignment is taken. I am responsible for all charges not covered by insurance/Medicare. I authorize Dr. Robert T. Spalding Jr., DPM to provide medical or surgical treatment to myself at my home, hospital or Dr. Spalding's offices known as Area Podiatry Center (APC).

Patient's Signature _____ Date _____
 Guardian (if minor) _____ Date _____

MEDICAL HISTORY

Name: _____ Date of Birth _____ Date _____

	YES	NO
Have you been hospitalized in the last 3 years? If yes, for what reason?	_____	_____
Have you seen a podiatrist before? If so, for what reason?	_____	_____
Are you under the care of a physician for any condition? Please specify.....	_____	_____
Do you have or have you ever had asthma?	_____	_____
Rheumatic Fever or Scarlet Fever?	_____	_____
Heart attack or heart disease?	_____	_____
Depression?	_____	_____
Problem with ears, mouth, throat?	_____	_____
Anemia?	_____	_____
Stroke or High Blood Pressure?.....	_____	_____
Glaucoma?.....	_____	_____
Ulcers or GI upset?.....	_____	_____
Jaundice?	_____	_____
Diabetes?	_____	_____
Epilepsy or Seizures?	_____	_____
Tuberculosis?	_____	_____
Osteoporosis?.....	_____	_____
Skin diseases?.....	_____	_____
Venereal Disease?	_____	_____
HIV Positive/AIDS?	_____	_____
Are you taking any medications or drugs now?	_____	_____
Are you allergic to penicillin or any other medication?	_____	_____
If yes, specify: _____		
Do you have prolonged bleeding problems?	_____	_____
Have you ever had surgery for a tumor or growth?	_____	_____
Are you pregnant?	_____	_____

SIGNATURE OF PATIENT/GUARDIAN

DATE