

PATIENT INFORMATION

Please PRINT and fill out ALL spaces

Patient: _____ Date: _____
(Last Name) (First)

Male _____ Female _____ Married _____ Single _____ Divorced _____ Widowed _____

Home Address: _____ Date of Blrth: _____

City: _____ State: _____ Zip: _____ Soc.Sec.#: _____

Home Phone #: _____ Second Phone #: _____

Work Status: Employed _____ Non-Employed _____ Student _____ Retired _____ Others _____

Employer: _____ Occupation: _____

Work Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ Driver's License #: _____

Referred
By: _____

Person to Contact in Case of Emergency?

Name: _____ Relationship: _____ Phone # _____

HEALTH INSURANCE INFORMATION

Please Submit All Insurance Information to the Receptionist

Name of Insurance Company: _____

Insurance I.D.#: _____ Group(plan)# _____

Circle SEE ABOVE if Self Insured if not please fill out Insured's Information below

Insured's Name: _____ Relationship to Insured: _____

Insured's Date of Birth : _____ Insured's Soc.Sec.# _____

Insured's Employer's Name: _____

Insured's Employer's Address & Tel#: _____

Secondary Insurance Company: _____

Insurance I.D.#: _____ Group(plan)#: _____

Insurance
Address: _____
(Address) (City) (State) (Zip) (Phone)

Insured Name: _____ Relationship to Insured: _____

ASSIGNMENT OF BENEFITS

I hereby authorize, Timothy S. Kneebone, D.P.M., to furnish to my insurance carrier(s) any and all requested information concerning my health care. I also authorize my insurance carrier(s) to pay Timothy S. Kneebone, D.P.M., directly for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I authorize the use of this signature on all insurance submissions.

PATIENT (print name): _____

Insured's Signature: _____ **Date:** _____

OVER>>>

Patient's name (print): _____

MEDICAL HISTORY

What is the reason for your visit? _____

Previous treatment by Podiatrist YES() NO() If so, when _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Please check)

	YES	NO		YES	NO
HIGH BLOOD PRESSURE	_____	_____	LIVER PROBLEMS	_____	_____
SCARLET FEVER	_____	_____	SWELLING OF FEET	_____	_____
RHEUMATIC FEVER	_____	_____	ARTHRITIS	_____	_____
GOUT	_____	_____	POLIO	_____	_____
KIDNEY PROBLEMS	_____	_____	EASY BRUISING	_____	_____
NUMBNESS OR TINGLING	_____	_____	BLEEDING COMPLICATION	_____	_____
LUNG PROBLEMS	_____	_____	HEART PROBLEMS	_____	_____
ASTHMA	_____	_____	CANCER	_____	_____
GASTRO INTESTINAL PROBLEM	_____	_____	VENEREAL DISEASE	_____	_____
DIABETES	_____	_____	HIV POSITIVE	_____	_____

Medication you are taking on a regular basis: _____

Major surgeries you have had in the past and complication: _____

Do you smoke? YES___ NO___ If yes, how many packs a day? _____

Are you Allergic to any of the following including medication? (Please circle)

PENICILLIN SULFA ASPIRIN CODEINE TAPE IODINE Check here if none___
LOCAL ANESTHETIC OTHER _____

GENERAL INFORMATION

Family Physician: _____ Dr.'s Phone #:(_____) _____

Address: _____ Last Visit: _____
(Address) (City) (State) (Zip)

Reason for last visit: _____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to Dr. Timothy Kneebone, D.P.M., to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature: _____ **Date:** _____