

**PATIENT INFORMATION**

*Please PRINT and fill out ALL spaces*

Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
(Last Name) (First)

Male \_\_\_\_\_ Female \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Home Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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:** \_\_\_\_\_