John C ZIMMERMAN DPM Scott R DAVIS DPM Craig T JEX DPM Heather A HENTO DPM

NEW PATIENT FORM

Date:

Last Name / Middle Initial / First:

Home Phone : Age:

Cell: Birthdate:

Work: Sex:

Email: Ethnicity: *please check / circle*

Languages Spoken: *Asian, Black, Caucasian, Hispanic, Other*

SSN:

Drivers License / ID#:

Address:

Mailing Address *if different from above:*

Patient Employer / Occupation:

☐ Full-time ☐ Part-time

Please check / circle :

☐ *Married* ☐ *Single* ☐ *Widowed* ☐ *Minor* ☐ *Separated* ☐ *Divorced* ☐ *Partnered*

Spouse / Partners Name:

Birthdate:

SSN:

Spouse's Employer / Occupation:

☐ Full-time ☐ Part-time

PARENT / GUARDIAN INFORMATION

for patients under eighteen years of age ,or using their parents insurance

Mothers Name: Fathers Name:

Mothers Birthdate: Fathers Birthdate:

Mothers Employer: Fathers Employer:

Mothers SSN: Fathers SSN:

Mothers Email: Fathers Email:

Who may we thank for referring you ?

If we're unable to reach you, whom may we contact ?

Name:

Relationship: Phone:

HISTORY

please check / circle to indicate

AIDS/HIV	**Circulatory Problems**	Hepatitis or Jaundice	Rheumatic Fever
Allergies to Anesthetics	Cigarette / Tobacco Use	High Blood Pressure	Shortness of Breath
Anemia	*If so, how many years?*	Kidney Problems	Sinus Problems
Angina		Liver Disease	**Stents**
Arthritis	**Diabetes**	Low Blood Pressure	Stroke
Artificial Heart Valves / Joints	Ear Problems	**Neuropathy**	Swelling in Feet or Ankles
Asthma	Epilepsy	**Pacemaker**	Swollen Neck Glands
Back Problems	Eye Problems	Phlebitis	Tuberculosis
Bleeding Disorders	Fainting	Psychiatric Care	Ulcers
Cancer	Foot or Leg Cramps	Radiation Treatment / Chemo	Varicose Veins
Chemical Dependency	**Gout**	Rash	Unexpected Weight Loss
Chest Pain	**Headaches**	Respiratory Disease	NONE
	Heart Disease		

Height: Weight: Shoe Size:

Are you, or might you be pregnant ?

Surgeries you have had in the last two years :

Hospitalization other than for the surgeries listed :

Are you now, or have you been, under another doctor's care for any reason in the past two years ? *If so please explain.*

Family Physician: Last Seen:

What is the **chief complaint** for which you're seeking treatment? Date of injury?

Have you been to a podiatrist before ? *If so please indicate.*

Doctor : Last Seen:

Is there a personal or family history of **diabetes**? *If so please indicate.*

DIABETIC DOCTOR : Last Seen:

MEDICATIONS

Please include prescriptions / over-the-counter

Pharmacy: Location:

ALLERGIES

please check / circle to indicate

Adhesive / Tape	Aspirin	Iodine	Penicillin	*Other:*
Anticoagulant Therapy	Codeine	Latex	Seafoods	
	Demerol	Local Anesthetics	Sulfa	NO KNOWN

PATIENTS INSURANCE

IS THE REASON FOR THIS VISIT AN INJURY DUE TO AN AUTO ACCIDENT? Yes No
IS THE REASON FOR THIS VISIT A (WORK RELATED INJURY?) Yes No

Date of Injury: _____

Name of Workers' Comp Carrier:

Workers' Comp Address: _____
Phone : _____
Adjusters name: _____
Claim # _____

Primary Insurance Company:

Subscriber Name: _____
Birthdate: _____
Subscribers Home Address: _____
Subscribers Phone: _____
Relationship to Patient: _____

Insurance ID Number: _____ Group Number: _____

Secondary Insurance Company:

Subscriber Name: _____
Birthdate: _____
Subscribers Home Address: _____
Subscribers Phone: _____
Relationship to Patient: _____

Insurance ID Number: _____ Group Number: _____

Third Insurance Company:

Subscriber Name: _____
Birthdate: _____
Subscribers Home Address: _____
Subscribers Phone: _____
Relationship to Patient: _____

Insurance ID Number: _____ Group Number: _____