

| | | | | | | | |
|--|---|----------------------|--|-----------------------------------|---|---|------------|
| Last Name | First Name | MI | Age | D.O.B / / | Sex | Home Phone | Work Phone |
| Street Address | | City | Zip Code | | Social Security # | Marital Status (circle) single/married/divorced widowed/separated | |
| Policy Holder's Name | Your relationship to policy holder self / spouse / child / | | Name and address of person responsible for charges | | | | |
| Primary Insurance Name | Secondary Insurance Name | | Employer Name and Address | | | | |
| How did you hear about our office? (See below) | | | | | | | |
| [] Doctor's Office, please specify: | | [] Patient Referral | | | [] Insurance Handbook [] Yellow Pages | | |
| | | [] Other : | | | | | |
| Personal Physician | | | | If any, name of former Podiatrist | | | |

Person to contact in an EMERGENCY

Name: Phone: Relationship

PLEASE INDICATE IF THERE IS ANY PERSONAL (SELF) OR FAMILY HISTORY OF THE FOLLOWING

(Please check if applicable)

| SELF | FAM | | SELF | FAM | | SELF | FAM | |
|------|-----|---------------|------|-----|--------------------|------|-----|-------------------------|
| [] | [] | HEART TROUBLE | [] | [] | RHEUMATIC FEVER | [] | [] | BLEEDING DISORDERS |
| [] | [] | DIABETES | [] | [] | KIDNEY DISEASE | [] | [] | ARTHRITIS,DEGENERATIVE) |
| [] | [] | ASTHMA | [] | [] | LIVER DISEASE | [] | [] | ARTHRITIS (RHEUMATOID) |
| [] | [] | EPILEPSY | [] | [] | SEASONAL ALLERGIES | [] | [] | HIGH BLOOD PRESSURE |
| [] | [] | SKIN DISEASE | [] | [] | VENEREAL DISEASE | [] | [] | HEPATITIS |
| [] | [] | ANEMIA | [] | [] | GLAUCOMA | [] | [] | TUBERCULOSIS |
| [] | [] | CANCER | [] | [] | GOUT | [] | [] | SKIN ULCERS |
| [] | [] | POOR HEALING | [] | [] | THYROID PROBLEMS | [] | [] | STOMACH ULCERS |

ARE YOU A SMOKER? [YES] [NO] IF YES, # OF YRS []

FEMALES ONLY: ARE YOU PREGNANT? Y//N

HAVE YOU EXPERIENCED ANY BAD EFFECTS FROM: (check below if applicable)

| | | | | | |
|-----|-----------------|-----|----------------------|-----|--------------|
| [] | NOVOCAIN | [] | TAPE PRODUCTS | [] | CODEINE |
| [] | PENICILLIN | [] | ANTIBIOTICS | [] | ASPIRIN |
| [] | IODINE PRODUCTS | [] | PAIN KILLERS | [] | LATEX |
| [] | SULFA DRUGS | [] | ANTI INFLAMATORY MED | [] | OTHER: _____ |

PLEASE LIST ANY MEDICATIONS THAT YOU ARE PRESENTLY TAKING:

WHAT IS YOUR MAJOR FOOT COMPLAINT?

AUTHORIZATION FOR TREATMENT

I hereby give permission to the podiatrists of the HARTFORD PODIATRY GROUP and affiliates to administer and perform such procedures as may be deemed necessary for the diagnosis and / or treatment of my foot condition.

Today's Date: [/ /] Signature: X

FOR COMPUTER BILLING PURPOSES

PATIENT NAME: _____ DATE: _____

I request that payment of authorized Medicare/Health insurance benefits be made to me or on my behalf to the Hartford Podiatry Group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: X _____