



JESSICA M. LEVY, D.P.M.

**PATIENT INFORMATION AND HISTORY**

Today's Date \_\_\_\_\_ Patient # \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Date Of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

If Minor, Parent's Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone # \_\_\_\_\_ Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employer's Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer's Telephone # \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone # \_\_\_\_\_ Social Security # \_\_\_\_\_

What is the name of your general medical doctor? \_\_\_\_\_

Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_

How did you hear of our office? \_\_\_\_\_

Do you have medical insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

Medicare: Yes \_\_\_\_\_ No \_\_\_\_\_ ID # \_\_\_\_\_

Medicaid: Yes \_\_\_\_\_ No \_\_\_\_\_ ID # \_\_\_\_\_

Primary Carrier \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Telephone # \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Secondary Carrier (If Any) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Telephone # \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Are you presently under the care of **any physician**? Yes \_\_\_\_\_ No \_\_\_\_\_

If **yes**, what For? \_\_\_\_\_

Have you been hospitalized in the past **five** years? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what for? \_\_\_\_\_

Are you or could you be **pregnant**? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you **ever** been treated by a **podiatrist** before? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what for? \_\_\_\_\_

**What foot or ankle problem do you presently have?** \_\_\_\_\_

Are you taking **any medication** at the present time? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list: 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_

4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_

List **any drugs, ointments** or **tapes** that you are **allergic** to? (Please List): \_\_\_\_\_

**Medical History (Place an (X) next to conditions you have been diagnosed as having)**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Heart Trouble       | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Eye Disease         |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Arthritis           |
| <input type="checkbox"/> Circulation Problem | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Infections          |
| <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Sinus Problems      | <input type="checkbox"/> AIDS                |
| <input type="checkbox"/> Phlebitis           | <input type="checkbox"/> Gastritis           | <input type="checkbox"/> Steroid Therapy     |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Stomach Ulcers      | <input type="checkbox"/> Hormone Therapy     |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Birth Control Pills |
| <input type="checkbox"/> Hypothyroid         | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Drug Reactions      |
| <input type="checkbox"/> Hyperthyroid        | <input type="checkbox"/> Liver Disease       |  |
| <input type="checkbox"/> <b>Other</b> _____  |  |  |

**Authorization Signature**

In signing this form I understand the following:

- 1 This form and its information may be released to all my insurance carriers.
- 2 I authorize insurance payments directly to my doctor, but understand that I am ultimately responsible for my bill.
- 3 I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- 4 I permit a copy of this authorization to be used in place of the original.

Print Name \_\_\_\_\_

Authorization Signature \_\_\_\_\_ Date \_\_\_\_\_