ANKLE & FOOT SPECIALISTS OF DOUGLAS COUNTY

NORMAN I. KORNBLATT, D.P.M.

Welcome To Our Office

Please Complete Both Sides of this Form

Please Print All Information

PATIENT INFORMATION

PATIENT'S FULL NAME	ADDRESS	CITY/STATE	ZIP CODE
HOME NO.	WORK NO.	CELL NO.	ALTERNATIVE NO.
SOCIAL SECURITY NO.	EMPLOYER	CITY/STATE	
SEX: M F MARITAL STATUS ❑ MARRIED ❑ SINGLE ❑ WIDOW(ER) ❑ DIVORCED ❑ SEPARATED (X)	BIRTHDATE	OCCUPATION	
SPOUSES NAME	SPOUSES BIRTHDATE	SPOUSES EMPLOYER	SPOUSES WORK NO.
DATE OF FIRST SYMPTOM OR INJURY	HAVE YOU EVER HAD SAME OR SIMILAR CONDITION? If so when?		
WHAT BRINGS YOU TO THE OFFICES TODAY?			

RESPONSIBLE PARTY INFORMATION

NAME IN FULL	ADDRESS		CITY/STATE	ZIP CODE
HOME NO.	WORK NO.	SOCIAL SECURITY NO.	EMPLOYER	CITY/STATE
OCCUPATION	MARITAL STATUS ❑ MARRIED ❑ SINGLE ❑ WIDOW(ER) ❑ DIVORCED ❑ SEPARATED (X)			RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME	PERSON CARRYING INSURANCE		IS INSURANCE THROUGH EMPLOYER? YES NO	
EMPLOYER	INSURED'S BIRTHDATE			
PATIENT'S RELATIONSHIP TO INSURED ❑ SELF ❑ CHILD ❑ SPOUSE ❑ OTHER	POLICY NUMBER	GROUP NUMBER	INSURED'S SOCIAL SECURITY NO.	
SECONDARY INSURANCE COMPANY NAME	PERSON CARRYING INSURANCE		IS INSURANCE THROUGH EMPLOYER? YES NO	
EMPLOYER	INSURED'S BIRTHDATE			
PATIENT'S RELATIONSHIP TO INSURED ❑ SELF ❑ CHILD ❑ SPOUSE ❑ OTHER	POLICY NUMBER	GROUP NUMBER	INSURED'S SOCIAL SECURITY NO.	

PERSON/RELATIVE TO BE CONTACTED IF NECESSARY

NAME	ADDRESS		TELEPHONE
RELATION	CITY	STATE	ZIP CODE

WHOM MAY WE THANK FOR REFERRING YOU? (please circle)

1. SOUTHERN BELL YELLOW PAGES
2. DOUGLAS COUNTY YELLOW PAGES
3. SAW YOUR SIGN
4. ANOTHER PATIENT _____
5. LISTED IN INSURANCE BOOK
6. OTHER

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize Release of any Medical Information Necessary to Process this Claim and Authorize Payment of Medical Benefits to Physician or Supplier for Services Rendered.

SIGNED **X**

It is the policy of our office that all fees are due at the time services are rendered, either cash, check or credit card, UNLESS prior arrangements have been made. We welcome frank discussion of services and fees prior to treatment in order to avoid misunderstandings. We will be pleased to provide you with a complete standard claim form which you should then submit to your employer or insurance company for reimbursement; you may attach your personal claim form to the one completed by our office to expedite processing. Regardless of insurance coverage, you are personally responsible for payment of your account within the credit policy of this office.

All accounts over 30 days are subject to a $3.00 per month service charge.

I prefer to pay for today's visit by ❑ cash ❑ check ❑ MasterCard / Visa / Discover

X _____

SIGNATURE OF THE PERSON RESPONSIBLE FOR THIS BILL **DATE**

MEDICAL HISTORY

The following information is important for your maximum safety and optimum care.
This information will be held in utmost confidence by this office.

Patient's Name _____ Age _____

Describe your foot/ankle problem _____

_____

_____

CIRCLE THE CORRECT ANSWER AND COMPLETE ANY QUESTIONS WHICH APPLY TO YOU.

1. When was your last medical examination? Date _____
2. Are you under the care of a physician now? ..... Yes No
3. What is your physician's name? _____
4. Do you have, or have you ever had any serious illness? ..... Yes No
   Please list your illness(es) _____
5. Have you had any previous surgeries? ..... Yes No
   Please list the type of surgery and the year performed _____
   _____
6. Do you take any medication(s) on a daily basis? ..... Yes No
   Please list your medication(s) _____
   _____
7. WOMEN are you pregnant? ..... Yes No
8. Do you have any allergies? ..... Yes No
   Please list your allergies _____
   _____
9. Are you being treated for or have you ever been treated for:

High Blood Pressure	Yes	No	Asthma	Yes	No
Heart Disease	Yes	No	Gout	Yes	No
Diabetes	Yes	No	Arthritis	Yes	No
Anemia	Yes	No	Epilepsy, Seizure or Nerve Disease	Yes	No
Tuberculosis	Yes	No	Rheumatic Fever	Yes	No
Skin Rashes or Hives	Yes	No	Kidney or Bladder Trouble	Yes	No
Thyroid Disease	Yes	No	Cancer or Tumor	Yes	No
Stomach Ulcers or Intestinal Disease	Yes	No	Emphysema, Bronchitis or Lung Disease	Yes	No
Circulation Problems	Yes	No	Liver Disease or Hepatitis	Yes	No
Hormonal Disorders	Yes	No	Unexplained Weight Loss	Yes	No
Frequent Infections	Yes	No	Trouble Healing	Yes	No

   Other not listed? _____
10. Are you allergic or have you reacted adversely to any of the following:

Local Anesthesia	Yes	No	Penicillin or other Antibiotic	Yes	No
Sulfa Drugs	Yes	No	Codeine	Yes	No
Aspirin	Yes	No	Iodine	Yes	No
Tape or Band-Aids	Yes	No	Sedatives	Yes	No

11. Do you have any artificial joints? ..... Yes No
12. Shoe Size _____ Current Weight _____ Height _____
13. Is there a family history (blood relative) of: (If yes, circle).

Diabetes	Heart Disease	Arthritis	Bleeding Disorder
Hypertension	Neurological Disorders	Stroke	Circulation Problems in Legs or Feet

X _____
Signature of Patient, Parent or Guardian **Date**