

QUALITY FOOT CARE

WELCOME TO OUR OFFICE

Please print and complete the following information for your case history file.

Last Name		First	Middle Initial	Today's Date	
Spouse's Name, Parent' sor Gaurdian's Name if a Minor			Birth Date	Age	
Residence Address	City	State	Zip	Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
Home Phone	Social Security Number		E-Mail Address		
Name of Employer		Occupation	Business Phone		
Whom may we thank for referring you?			Address		
Name, address and phone of contact in case of emergency				Relationship	
If other than patient, name and address of person responsible for this account					
List any medical conditions you have (allergies, impairments, etc.)					
Name of family physician		Phone	Are you currently under your physician's care? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, for what		May we contact your physician for your health records? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you had previous treatment by a Podiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No	When:	For what:			
My chief foot complaint is:					
This condition(s) has existed for:					
What medicines do you take regularly?					

Do you have or have you had any of the following (*do not know)

Yes			No			*DNK			Yes			No			*DNK		
Foot or Leg Injuries.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Novocaine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Foot or Leg Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Foot or Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adhesive Tape	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Foot or Leg Numbness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Materials.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Knee Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Unequal Leg Length.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foods.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Weak Ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hardening of Arteries ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (if so describe)....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bunions.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____					
Foot Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____					
Toe Nail Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____					
Low Back Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prone to Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____					

I hereby give Dr. Lefkowitz permission to examine and treat my feet. I authorize use of this form on all my insurance submissions. I authorize release of information to all my Insurance Companies. I understand that I am responsible for my bill. I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies. I authorize payment direct to my doctor. I permit a copy of this authorization to be used in place of the original.

Signature: _____