PATIENT INFORMATION SHEET

PLEASE READ CAREFULLY AND PRINT YOUR ANSWERS TO ALL QUESTIONS.

LAST NAME:_____FIRST NAME_____MIDDLE_____

ADDRESS:_____CITY_____STATE:_____ZIP_____

PHONE #(____) _____SOCIAL SECURITY #_____

SEX: MALE_____ FEMALE_____ BIRTHDATE:_____
SINGLE ☐ MARRIED ☐ OTHER ☐
ARE YOU EMPLOYED? FULL-TIME ☐ PART-TIME☐ EMAIL ADDRESS_____
YOUR EMPLOYER:_____
ADDRESS:_____CITY_____STATE: _____ZIP_____
WORK PHONE:(_____)_____ **REFERRED BY:**_____
ARE YOU A STUDENT FULL-TIME ☐ PART-TIME ☐

RESPONSIBLE PARTY (IF OTHER THAN PATIENT): SPOUSE ☐ PARENT ☐ OTHER ☐
LAST NAME:_____FIRST NAME_____MIDDLE_____
ADDRESS:_____CITY_____STATE_____ZIP_____
PHONE #(____) _____SOCIAL SECURITY #_____
EMPLOYER: _____
ADDRESS:_____CITY_____STATE: _____ZIP_____
WORK PHONE:(_____)_____ REFERRED
BY:_____
NEAREST RELATIVE NOT LIVING WITH YOU THAT WE CAN CONTACT IN EMERGENCY:
_____PHONE NUMBER: (_____)_____

PRIMARY INSURANCE:
INSURANCE COMPANY:_____
POLICY NO._____GROUP NO._____
ADDRESS:_____CITY_____STATE_____ZIP_____
PHONE#(____)_____HAVE YOU MET YOUR DEDUCTIBLE?_____

SUBSCRIBER (IF OTHER THAN PATIENT):
LAST NAME:_____FIRST NAME_____MIDDLE_____
ADDRESS:_____CITY_____STATE:_____ZIP_____
PHONE #(____) _____SUBSCRIBER'S BIRTHDATE:_____

SECONDARY INSURANCE:
INSURANCE COMPANY:_____
POLICY NO._____GROUP NO._____
ADDRESS:_____CITY_____STATE_____ZIP_____
PHONE#(____)_____HAVE YOU MET YOUR DEDUCTIBLE?_____

SUBSCRIBER (IF OTHER THAN PATIENT):
LAST NAME:_____FIRST NAME_____MIDDLE_____
ADDRESS:_____CITY_____STATE:_____ZIP_____
PHONE #(____)_____SUBSCRIBER'SBIRTHDATE:_____

I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL.
( ) CASH ( ) CHECK ( ) M/C ( ) VISA ( ) A/E
I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANIES. I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS, RELEASE OF INFORMATION TO MY INSURANCE COMPANIES AND PAYMENT DIRECT TO THE DOCTOR. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

PATIENT'S SIGNATURE_____**DATE**_____

PLEASE COMPLETE THE FOLLOWING QUESTIONS:

WHAT IS YOUR CHIEF COMPLAINT? _____

_____

_____

IS YOUR GENERAL HEALTH GOOD ( ) FAIR ( ) POOR ( )

DO YOU HAVE DIABETES? YES ( ) NO ( ) BORDERLINE ( )

DATE OF LAST BLOOD SUGAR?_____

IS THERE A HISTORY OF DIABETES ( ) TUBERCULOSIS ( ) CANCER ( ) IN YOUR FAMILY?

LIST ALL SURGERIES AND OR ILLNESSES:_____

_____

_____

ARE YOU TAKING ANY MEDICATION AT THE PRESENT TIME? YES ( ) NO ( ) LIST MEDICATIONS:

_____

_____

HAVE YOU EVER BEEN HOSPITALIZED? YES ( ) NO ( ) IF YES, STATE DATES AND REASON:_____

ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY REASON? YES ( ) NO ( )
NAME OF FAMILY PHYSICIAN_____

IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING, PLEASE CHECK:

HEART TROUBLE ☐	KIDNEY TROUBLE ☐	HIGH BLOOD PRESSURE ☐	RHEUMATIC FEVER ☐
VARICOSE VEINS ☐	ARTHRITIS ☐	ASTHMA ☐	LIVER TROUBLE ☐
ANEMIA ☐	BLOOD DISEASE ☐	CANCER ☐	PROLONGED BLEEDING
☐TUBERCULOSIS ☐	EPILEPSY ☐	STOMACH ULCERS ☐	HIV POSITIVE ☐
CIRCULATION DISEASE ☐	SHORTNESS OF BREATH ☐	DIFFICULTY IN HEALING ☐	

HAVE YOU HAD AN ALLERGY OR REACTION TO:
( ) PENICILLIN ( ) ASPIRIN ( )CORTISONE ( ) CODEINE ( ) TAPE
( ) ANY ANTIBIOTICS ( ) NOVOCAINE ( ) SULFA ( ) OTHERS_____

I HEREBY GIVE PERMISSION TO DR. NIKNAFS TO ADMINISTER TREATMENT; AND TO PERFORM SUCH MINOR OPERATIVE PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND OR TREATMENT OF MY FOOT AND LEG CONDITION.

PATIENT'S SIGNATURE_____**DATE**_____

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES INCURRED EVEN THOUGH INSURANCE MAY HAVE BEEN FILED. IN THE CASE THAT MY INSURANCE CARRIERS FAIL TO MAKE PROMPT PAYMENT, I HEREBY GIVE MY PERSONAL GUARANTEE OF PAYMENT FOR ALL CHARGES INCURRED.

SIGNED:_____**DATE:**_____

IF IT BECOMES NECESSARY FOR DR. NIKNAFS TO SUBMIT A CLAIM FOR INSURANCE, I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION FOR ANY HOSPITAL OR OFFICE TREATMENT I RECEIVE.

SIGNED:_____**DATE:**_____

I HEREBY ASSIGN MEDICAL BENEFITS TO DR. NIKNAFS FOR SERVICES AS DESCRIBED BY ANY CLAIM PROCESSED.

SIGNED:_____**DATE:**_____