

PLEASE COMPLETE IN FULL

PLEASE PRINT

Patient Name _____

Date of Birth _____ Age _____ Sex M F

Home Address _____

City _____

State _____ Zip Code _____

Employer _____ Work Phone _____

Emergency Contact & Phone# _____

Pharmacy _____

Today's Date _____

Marital Status Married Single

Email _____

Phone # _____

Cell # _____

Referred By: Internet Physician

Friend _____
(Physician's Name)

Family Physician _____

Former Foot Doctor _____

Language _____

Last 4 digits Social Security # _____

WHAT ARE YOUR FOOT AND ANKLE CONCERNS? _____

ANY PAIN / CONCERNS WITH HIP, KNEE'S OR BACK? _____

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Are you in good health? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is there any personal or family history of diabetes? Who is your diabetes doctor? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever experienced any allergies to any medications?
If yes, which one(s)? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever been treated for heart trouble, asthma, epilepsy, rheumatic fever, kidney or liver involvement? If yes, which one(s)? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you had any serious illnesses or operations? If yes, please list _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Eye Exam? When? _____ Doctor? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had stomach ulcers or problems taking medications such as Aspirin or Motrin? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Use of Alcohol? If yes, average per day / week _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Use of Tobacco? If yes, average per day / week _____ | <input type="checkbox"/> | <input type="checkbox"/> |

I hereby give my permission to **DR. JOHN D. ARSEN** and/or **DR. KRISTI S. SCHONS** to administer treatment and to perform such minor procedures as may be deemed necessary in the diagnosis and/or treatment of my foot or hand condition.

I also request that payment of authorized benefits be made to the provider on my behalf for any services furnished me by this provider. I authorize **DR. JOHN D. ARSEN** and/or **DR. KRISTI S. SCHONS** to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related service. I understand that I am ultimately responsible for the balance on my account for any professional services rendered.

DATE _____ SIGNATURE _____

LEGAL GUARDIAN (if patient is under 18) _____