

## **PATIENT INFORMATION**

Name \_\_\_\_\_ SSN # \_\_\_\_\_

Date \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ Apt. \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Driver's License # \_\_\_\_\_

Work Phone \_\_\_\_\_ Occupation \_\_\_\_\_

(circle one)    Single    Married    Separated    Divorced    Widowed

Name of Spouse (Parent if Minor) \_\_\_\_\_

Spouse's/Parent's Occupation \_\_\_\_\_

Spouse's/Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

### PERSON TO CONTACT IN CASE OF EMERGENCY

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Relationship \_\_\_\_\_ ( If patient is a minor: name of parent, guardian, etc.)

## **HEALTH INSURANCE INFORMATION** **PLEASE READ AND SIGN**

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other patient responsible balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH THE DOCTOR.

If this account is assigned for collection and/or suit, collection costs and/or attorneys fees, and/or court costs will be added to the total amount due.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medical, private insurance, and other health plans to: Mafutaga S. Tagaloa-Tulifau, D.P.M.

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

## HEALTH INSURANCE INFORMATION

Name of Insurance Company \_\_\_\_\_ I.D. # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Group # \_\_\_\_\_

Name of Co-Insurance \_\_\_\_\_ I. D. # \_\_\_\_\_

Policy \_\_\_\_\_ Group # \_\_\_\_\_

## HEALTH INFORMATION

Please describe your foot or ankle problem: \_\_\_\_\_

How long has it bothered you? \_\_\_\_\_ wk/mo/yr (circle one)

Have you seen another doctor? YES NO

Patients Primary Physician: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date you last visited your physician \_\_\_\_\_

Date of last EKG: \_\_\_\_\_ Date of last chest X-ray: \_\_\_\_\_

Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

Are you in good health? YES/NO

Are you now (or have been in the last two years) under the care of a physician for a chronic illness? YES/NO

Have you ever been hospitalized or had an operation? YES/NO  
If YES, please describe: \_\_\_\_\_

Have you ever experienced any side effects from Novocaine, Penicillin, Codeine or any other drug? YES/NO

Do you have any allergies? YES/NO  
If YES, please list: \_\_\_\_\_

Are you presently taking any medications? YES/NO  
If YES, please list: \_\_\_\_\_

Female patients: Are you pregnant or plan to be in the near future? YES/NO

Have you ever had any injuries, broken bones, or operations in your feet, ankles, or legs? YES/NO  
If YES, please describe: \_\_\_\_\_

**Have you ever been treated for any of the following:  
(Please circle YES or NO)**

Asthma	YES/NO	Anemia	YES/NO
Arthritis	YES/NO	Back Problems	YES/NO
Blood Clots	YES/NO	Bronchitis	YES/NO
Cancer	YES/NO	Diabetes	YES/NO
Emphysema	YES/NO	Heart Trouble	YES/NO
Hepatitis	YES/NO	High Blood Pressure	YES/NO
HIV Infection	YES/NO	Kidney Problems	YES/NO
Tuberculosis	YES/NO	Pneumonia	YES/NO
Liver Problems	YES/NO	Seizures	YES/NO
Rheumatic Fever	YES/NO	Ulcers	YES/NO

Is there ANY OTHER important information about YOUR HEALTH? YES/NO

If yes, please describe: \_\_\_\_\_

Does anyone you know have an ankle, heel, foot or problem, which they are not taking care of right now and whom you'd like to see get relief? Please state their name, address and type of problem below.

We will contact them.

Name \_\_\_\_\_ Relationship to you \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Who may we thank for referring you to our office?

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_