WELCOME TO OUR OFFICE
PATIENT INFORMATION

Last name:	First name:	Middle initial:	Date of birth:

Street address:	City:	State:	Zip code:

Phone (home):	☐Single ☐Married ☐Divorced ☐Widow(er)	Name of Spouse:	Social Security #:

Phone (business):	Occupation:	How did you learn of our office?

Briefly state your foot problem:

Have you had your feet cared for previously? Please check one:

☐ Yes ☐ No ☐ Podiatrist ☐ Other

Have you had any of the following? Please check:

_____Breathing problems	_____Diabetes	_____High blood pressure
_____Seizures	_____Gout	_____Arthritis
_____Blood disease	_____Heart conditions	_____Kidney trouble
_____Tuberculosis	_____Liver Trouble	_____Stomach trouble
_____Vein-artery problem	_____Artificial joints	_____Rheumatic Fever
_____Other	_____Anxiety/Depression	_____H.I.V.

Do you have any allergies? ☐ Yes ☐ No If yes, please list:

Name of family physician:	**Name of Pharmacy:**

What medicines do you take regularly?

HEALTH INSURANCE AND PAYMENT INFORMATION

If you have medical insurance, we will be happy to process your insurance claim providing your deductible has been met. **You must** have your insurance identification card with you. **All other means of payment are due when services are rendered.**

I wish to take care of my medical services today by:

☐ Cash ☐ Check ☐ Mainecare ☐ Medicare ☐ Anthem ☐ Other insurance

Please attach your insurance card for photocopy

I certify that I have completed the above to the best of my knowledge and give permission for Dr. Steinmetz to examine and treat me.

Patient, Parent or Guardian Signature:_____ Date:_____