

WELCOME TO OUR OFFICE

PATIENT INFORMATION

Last name:	First name:	Middle initial:	Date of birth:	
Street address:		City:		State:
				Zip code:
Phone (home):	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Divorced <input type="checkbox"/> 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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Gout | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Heart conditions | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Liver Trouble | <input type="checkbox"/> Stomach trouble |
| <input type="checkbox"/> Vein-artery problem | <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Other | <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> H.I.V. |

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

Name of family physician:	Name of Pharmacy:
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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: _____