

**Welcome To Our Office:** Complete the following information for your file. (PLEASE PRINT)

Patient's Name (Last)		(First)	(M.I.)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Age
Social Security Number	Home Phone Number	Cell Phone Number	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other			
Home Address			City	State	Zip Code	
Name of Employer			Business Phone	Occupation		
Primary Card Holder / Relationship	Social Security Number	Date of Birth	Occupation			
Employer	Business Address			Business Phone		
Contact Name in Case of Emergency	Address & Phone Number			Relationship		
<b>Primary Medical Insurance</b>		Name of Policy Holder	<b>Secondary Medical Insurance</b>		Name of Policy Holder	
<b>Family Physician</b>	Phone #	Are you currently under Physician's care? <input type="checkbox"/> No <input type="checkbox"/> Yes For What?		Date Last Seen?		
Who may we thank for referring you to our office?		<b>Family History</b> <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Seizures <input type="checkbox"/> Foot Problems				
<b>Social History</b>			Height	Weight		
Tobacco (ppd) _____ Caffeine (cpd) _____ Alcohol _____ Illicit Drug Use _____						
<b>Please describe your chief foot / ankle complaint:</b>						
Have you been treated for this before?		What was done?			Previous doctor:	
<b>Past Medical History:</b>						
<input type="checkbox"/> Cancer	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Arthritis				
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pacemaker / Heart Disease	<input type="checkbox"/> Phlebitis / Blood Clots				
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stroke				
<input type="checkbox"/> Bleeding Disorder / Anemia	<input type="checkbox"/> Liver Disease / Hepatitis	<input type="checkbox"/> Cholesterol				
<input type="checkbox"/> Gastric Ulcers	<input type="checkbox"/> HIV/Aids	<input type="checkbox"/> Other _____				
<input type="checkbox"/> Gout	<input type="checkbox"/> Thyroid					
<b>Medications</b>	<b>Allergies</b>	<b>Reaction</b>	<b>Past Surgeries</b>	<b>Date</b>		
<p>I hereby give Paul Angotti, D.P.M., Anthony Anzalone, D.P.M., Kimberly Wilkie, D.P.M., and Michael Troiano, D.P.M. permission to administer treatment and perform such procedures as may be necessary for the diagnosis and treatment of my foot and/or ankle condition. Also, I authorize the release of any medical information necessary to process my claim. I also authorize payment to the above mentioned doctor(s) to keep my other medical care providers informed of my medical information, progress, and treatment obtained. I understand that as a courtesy, Foot &amp; Ankle Specialty Center, P.C. will file all insurance claims for me and I am ultimately responsible for payment of all services rendered. If my account becomes overdue and remains unpaid for over 90 days it may go to collections, therefore, an additional \$15.00 collection fee will be assessed and due from the patient.</p>						
Signature:				Date:		

Your email address \_\_\_\_\_