Dr. Steven E. Black, D.P.M

Podiatry – Foot Surgery

New Patient Information

Date___________________

Name _________________________________ Date of Birth _________________

Last Middle First

Address ____

Street City State Zip

Home Phone ____________________ Cell Phone ________________________

Preferred Phone Number for Calls and Messages _____________ (Home/Cell)

Email Address ____

Age _______ Sex _____ (M/F) Marital Status S / M / D / W

Social Security Number __________________________

Employer Name ______________________ Occupation ______________________

Work Phone _____________________________

In case of an emergency, who should we notify? ____________________________

Phone Number _______________________ Relationship to Patient ____________

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New Patient Information

Date___________________ Patient Name _____________________________

Primary Insurance ______________________________

Policy Holder Name _________________________

Policy Holder Date of Birth ___________________

Policy Number _______________________________ Group Number _____________

Secondary Insurance ______________________________

Policy Holder Name _________________________

Policy Holder Date of Birth ___________________

Policy Number _______________________________ Group Number _____________

Primary Physician ___________________________________

May we contact him/her for any medical information? _____________

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New Patient Medical History

Please describe the foot or ankle problem that brought you to the office today

____

____

Do you or have you ever had any of the following:

	Yes	No		Yes	No
Anemia			Hypertension		
Arthritis			Hepatitis		
Asthma			Stroke		
Bleeding Disease			Skin Disease		
Cancer			Rheumatism		
Diabetes			Gout		
Epilepsy			Nervous Condition		
Aids / HIV			Other		

Please describe any other medical problems you have that are not mentioned above

____

____

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New Patient Medical History (continued)

Please list the name and dosage of any medications you are currently taking (prescription and non prescription)

____

____

Please list allergies to medications that you may have

____

____

Does your family have any history of the following:

	Yes	No		Yes	No
Heart Disease			Arthritis		
Asthma			Diabetes		
Hypertension			Gout		
Cancer			Chemical Dependency		

Any other problems not listed above please list here: ___________________________

____

Do you smoke? YES NO If yes, number of packs per day ________

Do you drink? YES NO If yes, how many per week ________

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New Patient Medical History (continued)

Have you had any recent hospitalizations or surgeries? YES NO

If yes, please list them ____

____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of this staff responsible for errors that I may have made in the completion of this form.

Signature ____

Date ______________________________