



Welcome to the North Shore Podiatry Group

Patient: _____
First Name M.I. Last Name

Address: _____
Street City State Zip

Phones: _____ - _____ - _____ Home
 _____ - _____ - _____ Business
 _____ - _____ - _____ Cell
(Please indicate which number we may leave a message at with)

Date of Birth: ____/____/____ Email: _____ Spouse or Parent Name: _____

Employer: _____
Address City State Zip

Social Security #: _____ - _____ - _____ Occupation: _____

Personal Physician: _____
Name Phone Date of Last Visit

Pharmacy: _____
Name City Phone

Emergency Contact: _____
Name Phone

How did you learn about The North Shore Podiatry Group (Please check):
____ Physician (Dr. _____) ____ Family/Friend (Name: _____)
____ Co-worker (Name: _____) ____ Insurance Company ____ Internet Search
____ Phone Book ____ Health Fair/Lecture ____ Walk by ____ Other: _____

Cardholder Information:

Name of insured/responsible party Date of Birth

Address Employer

City State Zip Social Security #

I authorize the release of any medical information necessary to process the insurance claim. I authorize payment of medical benefits including government benefits to The North Shore Podiatry Group.

I understand that The North Shore Podiatry Group will file claims to my primary insurance carrier, but will not file to secondary insurance carriers. It is my responsibility to file these claims. I understand that any balances remaining are the sole responsibility of myself (parent/guardian).

Signature Print Name Date

PLEASE COMPLETE MEDICAL HISTORY ON BACK

Medical History

Current Medications:

1. _____
2. _____
3. _____

4. _____
5. _____
6. _____

Prior Surgeries & Approximate Dates:

1. _____
2. _____
3. _____

4. _____
5. _____
6. _____

Personal/Social History (Please check):

Height: _____ Weight: _____
Do you exercise regularly? Yes ___ No ___
Do you currently smoke cigarettes/cigars?
Yes ___ No ___ Quit ___
If yes, how many packs/day? _____ How many years? _____
Do you currently drink alcohol? Yes ___ No ___
If yes, how many drinks/week? _____

Allergies (Please check):

___ Penicillin ___ Sulfa
___ Adhesive tape ___ Latex
___ Iodine ___ Codeine
___ Lidocaine/Marcaine
___ NONE
Other _____
Foods _____

Have you ever had (Please check):

currently	past	
___	___	Anesthetic Problems (Personal/Family)
___	___	Arthritis
___	___	Asthma
___	___	Bleeding Disorders
___	___	Blood Clots/Phlebitis
___	___	Cancer (Type _____)
___	___	Circulation Problems
___	___	Diabetes
___	___	Digestive Problems
___	___	Epilepsy/Seizures
___	___	Fibromyalgia
___	___	Gout
___	___	Heart Disease/Heart Attack
___	___	High Blood Pressure
___	___	High Cholesterol
___	___	HIV+/AIDS
___	___	Irregular Heartbeat
___	___	Keloid Scarring

currently	past	
___	___	Kidney Disease
___	___	Liver Disease/Hepatitis
___	___	Low Back Pain
___	___	Lupus
___	___	Nerve Disease/Neuropathy
___	___	Pacemaker (Cardiologist: _____)
___	___	Pain Syndrome (RSD)
___	___	Parkinson's Disease
___	___	Psoriasis
___	___	Raynaud's
___	___	Rheumatic Fever
___	___	Sickle Cell Anemia
___	___	Skin Problems
___	___	Sleep Apnea
___	___	Stroke
___	___	Thyroid Disease
___	___	Vein Trouble
___	___	other: _____

Signature

____/____/____
Date