WELCOME TO OUR OFFICE

Patient's Name _____ (Last) _____ (First) _____ (Middle) _____ (Name of Spouse or Parent)

Address _____ (Street) _____ (City) _____ (State) Zip Code _____

Age _____ Date of Birth _____ Sex ____ Marital Status _____ Soc. Sec. No. _____

Home Phone (_____) _____ (Area Code) Work Phone (_____) _____ (Area Code) Cell Phone (_____) _____ (Area Code)

Occupation _____ Employer _____

(Parent's Information if Patient is a Minor)

Employer _____ (Spouse or Parent) _____ (Address) _____ (Phone)

How Did You Hear About Our Office? _____

Personal Physician _____

Person To Contact In Case Of An Emergency _____ (Relationship) _____ (Phone)

INSURANCE

Primary Insurance Company _____ Policy # _____

Secondary Insurance Company _____ Policy # _____

HEALTH HISTORY

What is your foot or ankle complaint? _____

_____

_____

Shoe Size _____ Height _____ Weight _____

Please list any allergies to medications or substances: _____

_____

Please list any medications you are taking: _____

_____

Are you now under the care of a doctor? Yes ☐ No ☐

If yes, please state why _____

Have you ever been hospitalized, had surgery or a serious injury? _____

If yes, please explain _____

_____

_____

Do you have a medical condition that requires antibiotics before any dental or surgical procedure? Yes ☐ No ☐

Females Only: Are you pregnant? Yes ☐ No ☐ If yes, how many months? ___ Are you nursing a child? Yes ☐ No ☐

Please check which substances you use and describe how much you use:

Alcohol ☐ _____ Caffeine ☐ _____

Do You Smoke? Yes ☐ No ☐ Packs/day ____ Years ____ Did you ever smoke? Yes ☐ No ☐ If you quit, when? _____

OVER

REVIEW OF SYSTEMS

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST:

☐ AIDS	☐ Diabetes	☐ Keloid	☐ Prostate Problem
☐ Alcoholism	☐ Emphysema	☐ Kidney Disease	☐ Psychiatric Care
☐ Anemia	☐ Epilepsy	☐ Liver Disease	☐ Raynaud's Disease
☐ Anorexia	☐ Glaucoma	☐ Measles	☐ Replacement Heart Valves
☐ Appendicitis	☐ Goiter	☐ Migraine Headaches	☐ Rheumatic Fever
☐ Arthritis	☐ Gonorrhea	☐ Miscarriage	☐ Sleep Apnea
☐ Artificial Joint Implants	☐ Gout	☐ Mononucleosis	☐ Slow Healing
☐ Asthma	☐ Heart Disease	☐ Multiple Sclerosis	☐ Stomach Ulcers
☐ Bleeding Disorders	☐ Heart Murmur	☐ Mumps	☐ Stroke
☐ Blood Clots	☐ Hepatitis	☐ Nervous Disorders	☐ Suicide Attempt
☐ Bronchitis	☐ Hernia	☐ Neuropathy	☐ Thyroid Problems
☐ Bulimia	☐ Herpes	☐ Osteoporosis	☐ Tonsillitis
☐ Cancer	☐ Hiatal Hernia	☐ Pacemaker	☐ Tuberculosis
☐ Cataracts	☐ High Blood Pressure	☐ Phlebitis	☐ Typhoid Fever
☐ Chemical Dependency	☐ High Cholesterol	☐ Pneumonia	☐ Ulcer of the Ankle or Foot
☐ Chicken Pox	☐ HIV Positive	☐ Polio	☐ Vaginal Infections
☐ Cortisone Treatment	☐ Hypertrophic Scar	☐ Poor Circulation	☐ Varicose Veins
☐ Cramps or Numbness of Feet	☐ Hypoglycemia	☐ Pregnancy	☐ Venereal Disease

PLEASE CHECK IF YOUR BLOOD RELATIVES HAD ANY OF THE FOLLOWING:

	DISEASE	RELATIONSHIP TO YOU
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS.

ASSIGNMENT OF BENEFIT

I authorize the payment of medical benefits directly to the physician

RELEASE OF INFORMATION

I authorize the release of any medical or other information necessary to process this and all future claims. Photostat is as valid as the original.

As a courtesy to other patients and due to the large volume of patients requesting an appointment with Dr. Nayfa, a $25.00 fee will be charged for a missed appointment not canceled prior to the appointment time.

Signature _____ **Date** _____

(Patient or Parent if Minor)

Thank You For Choosing Our Office!