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Welcome To Our Office

PATIENT INFORMATION

Patient Name, SS#, Birthdate, Street Address, City, State, Zip Code, Marital Status, Gender, Home Phone No., Patient or Responsible Party's Employer, Work Phone No., Work Address, City, State, Zip Code, How were you referred to this office?, Primary Care Physician, Phone No., City, Date of last visit with primary care physician, Emergency Contact, Phone No.

INSURANCE INFORMATION

If you don't have insurance, how will you be paying? [] Cash [] Check [] Check [] Credit Card
Insurance #1, Policy #, Group #, Insured's Name, SSN, Date of Birth, Mail Claim to: City, State, Zip Code, Insurance #2, Policy #, Group #, Insured's Name, SSN, Date of Birth, Insurance #2, Policy #, Group #

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and/or ankles. I authorize the release of any medical information necessary to process claims. I further authorize payment of medical benefits directly to the physician for services rendered. I understand that this office will assist me in every way possible to complete the necessary insurance forms, but I understand that I accept responsibility for payment of charges for services rendered. If my account becomes delinquent or is placed with an attorney I agree to pay all attorney and collection fees.

Signed _____ Date _____



Medical Information (Please check the following):

- | | | |
|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Blood Clots in your Legs or Feet | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Charcot Joint Disease | <input type="checkbox"/> Diabetes (circle Type I or II) |
| <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Eye Disease/Glaucoma/Cataracts | <input type="checkbox"/> Foot Cramps |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis A, B, or C |
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Thyroid Conditions | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Leg Cramps / Numbness |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mental Health Condition | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Pregnant, if female |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Sores/Ulcers on Feet | <input type="checkbox"/> Stomach Ulcers or Acid Reflux |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Varicose Veins or Phlebitis | |

If you answered yes to any of the above please elaborate:

Surgical History (please circle any that apply):

Angioplasty, Appendectomy, Back Surgery, Breast Biopsy, Bypass Surgery-Heart, Bypass Surgery-Leg, C-Section, Carotid Artery, Cataract, D & C, Dental Surgery, Gallbladder, Hernia Repair, Hysterectomy, Joint Replacement-Hip, Joint Replacement-Knee, Kidney Stones, Mastectomy, Pacemaker, Prostate Surgery, Stents-Heart, Stents-Leg, Tonsillectomy, Vein Stripping

Previous Foot Surgery (please circle any that apply):

Ankle Surgery, Spurs (other than heel spurs), Toenail Surgery, Heel Spur Surgery, Neuroma Excision, Hammertoe Repair, Plantar Fascial Release, Excision of Infected Bone, Toe Amputation, Bunion Surgery, Ankle Fracture Repair, Foot Fracture Repair, Ankle Fusion, Foot Fusion

Please list any medications that you are currently taking: _____

Family History (please circle if positive):

Has anyone in your family had any of the following:

Cancer Diabetes Heart Disease High Blood Pressure Stroke

Social History (please complete):

Tobacco Use Yes No Packs/Day: _____ No. Years: _____

Alcohol Use None Rarely Occasional Socially Daily

Are you allergic to:

- | | | | | | |
|----------------------------------|------------------------------------|--------------------------------------|------------------------------------|---|--------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Cortisone | <input type="checkbox"/> Adhesives/Tape | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Shellfish | <input type="checkbox"/> Anesthetics | <input type="checkbox"/> Latex | <input type="checkbox"/> Other _____ | |

If yes, what kind of reaction did you experience? _____

Please circle the kinds of foot problems you are currently experiencing: Right Foot Left Foot Both Feet

Heel Pain Ingrown Toenail Plantar Wart(s) Bunion Hammertoe Neuroma (Pinched Nerve)

Fractures Ankle Pain Diabetes Related Problem Other (please describe): _____