Timothy W. Bush, D.P.M.
Diplomate, American Board of Foot and Ankle Surgery
William A. Cohen, D.P.M.
Diplomate, American Board of Foot and Ankle Surgery

Welcome To Our Office

PATIENT INFORMATION - *PLEASE WRITE LEGIBLY*

Patient Name________________________________SSN_________________________Birthdate_________________

Street Address__________________________________City________________State_______Zip Code___________

Phone #_____________________________________Alternate Phone #_____________________________________

Email Address____Marital Status_____________Gender M / F

Emergency Contact Name________________________________ Phone No.________________________________

Preferred Language: English or _________________ Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

Race: ☐ Black/African American ☐ White/Caucasian ☐ Asian ☐ American Indian/Native Alaskan

☐ Hawaiian/Other Pacific Islander ☐ Other_________________________________ ☐ Decline

How were you referred to this office?____

Primary Care Physician______________________________________Phone #_________________________________

City________________________________Date of last visit with primary care physician_______________________

Pharmacy________________________**Address**_____________________________**Phone**_____________________

INSURANCE INFORMATION

If you don't have insurance, how will you be paying? ☐ Cash ☐ Check ☐ Credit Card

Insurance #1_____________________________Policy #__________________________Group #_________________

Insured's Name__________________________SSN_____________________________Date of Birth___________

Insurance #2_____________________________Policy #__________________________Group #_________________

Insured's Name__________________________SSN_____________________________Date of Birth___________

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 give my consent to receive the company newsletter at the email address above and understand my email address will not be sold or used for any purposes outside of the company.
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 or charges for services rendered. I also understand that all co-pays, co-insurance, and deductibles are due at the time of service. If my account becomes delinquent or is placed with a collection agency or attorney I agree to pay all attorney and collection fees.

____ _______________________
Signed **Date**

- Over Please -

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Please list all ***Medications and Dosages*** that you are currently taking:

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ARE YOU ALLERGIC TO:

☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Cortisone ☐ Adhesive/Tape ☐ Sulfa ☐ Iodine
☐ Shellfish ☐ Anesthetics ☐ Latex ☐ Other______________________________

*If yes, what kind of reaction did you experience?*______________________________

Medical Information (Please check the following that you are currently experiencing):

☐ Arthritis
☐ Autoimmune Disease
☐ Cancer
☐ Epilepsy/Seizures
☐ Heart Disease
☐ HIV Positive
☐ Thyroid Conditions
☐ Liver Disease
☐ Osteoporosis
☐ Rheumatic Fever
☐ Stroke

☐ Anemia
☐ Blood Clots in your Legs or Feet
☐ Charcot Joint Disease
☐ Eye Disease/Glaucoma/Cataracts
☐ Heart Murmur
☐ High Blood Pressure
☐ Kidney Disease
☐ Mental Health Condition
☐ Poor Circulation
☐ Sores/Ulcers on Feet
☐ Varicose Veins or Phlebitis

☐ Asthma
☐ Blood Disease
☐ Diabetes (circle **Type I or II**)
☐ Foot Cramps/Leg Cramps (circle one)
☐ Hepatitis A, B, or C
☐ High Cholesterol
☐ Numbness
☐ Mitral Valve Prolapse
☐ Pregnant, if female
☐ Stomach Ulcers/Acid Reflux (circle)

Surgical History (please circle all 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 all that apply):

Ankle Surgery, Spur (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

Family History—Has anyone in your family had any of the follow-

	Mother	Father	Sister	Brother	Mother's Grandmother	Father's Grandmother	Mother's Grandfather	Father's Grandfather
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Check if still Living	☐	☐	☐	☐	☐	☐	☐	☐

Social History (please complete):

Tabacco Use: Yes No Former Packs/Day:________________ No. Years:___________

Alcohol Use: None Rarely Occasional Socially Daily

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):___________________________

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