Richard S. Eisner, D.P.M., F.A.C.F.A.O.M.
Board Certified in Podiatric Orthopedics

WELCOME TO OUR OFFICE

In order to serve you properly, we need the following information. All information is strictly confidential. Please print clearly.

NAME:_____**M/F**_____ **DATE OF BIRTH:**_____/_____/_____

ADDRESS:_____**CITY:**_____**STATE:**_____**ZIP CODE:**_____

HOME TELEPHONE:_____-_____-_____ **WORK TELEPHONE:**_____-_____-_____**EXT.**_____

REFERRED TO OFFICE BY:_____

EMERGENCY CONTACT:_____**PHONE:**_____

If patient is a minor (18 year old.): PARENT'S NAME _____
HOME PHONE _____WORK PHONE_____

INSURANCE INFORMATION:

PRIMARY INSURANCE NAME:_____**POLICY #**_____
GROUP NUMBER/NAME:_____**SUBSCRIBER:**_____

SECONDARY INSURANCE NAME:_____**POLICY #**_____
GROUP NUMBER/NAME:_____**SUBSCRIBER:**_____

MEDICAL INFORMATION:

FAMILY PHYSICIAN:_____LAST EXAM**:**_____

MEDICATIONS:_____

ALLERGIES: [ ]None [ ]Penicillin [ ]Novocain [ ]Foods [ ]Materials [ ]Tape [ ]Other:_____

PAST MEDICAL HISTORY:

[ ] Diabetes [ ] High Blood Pressure [ ] Heart Disease [ ] Stroke [ ] Epilepsy [ ] Rheumatic Fever [ ] Liver Disease
[ ] Kidney Disease [ ] Stomach Ulcers [ ] Asthma [ ] Anemia [ ] Gout [ ] Bleeder [ ] Blood Disease [ ] Varicose Veins
[ ] Poor Circulation [ ] Arthritis [ ] Polio [ ] Prone to Infection [ ]Other:_____
[ ] Cancer:_____[ ] Numbness:_____[ ] Unequal Leg Length:_____
[ ] Low Back Pain:_____[ ] Alcohol Use-Drinks/Day:_____[ ] Smoking-Packs/Day:_____

SURGERIES: _____

Please describe your chief complaint: _____

_____

This condition has existed for: _____ DAYS _____ WEEKS _____ MONTHS _____ YEARS

I authorize the release of any medical information necessary to process medical claims and request that my insurance company pay directly to the Doctor. I also give Dr. Richard S. Eisner permission to examine and treat my feet. 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.

SIGNATURE: _____ **DATE:**_____

(If patient is a minor, parent's signature) : _____ **DATE:** _____