Richard S. Eisner, D.P.M., F.A.C.F.A.O.M.

Diplomate, American Board of Podiatric Medicine

WELCOME TO OUR OFFICE

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

NAME:_____ **[ ]Male [ ]Female Date of Birth:**_____/_____/_____

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

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

CELL PHONE:_____-_____-_____ **REFERRED TO OFFICE BY:**_____

e-Mail:_____

EMERGENCY CONTACT:_____**PHONE:**_____

MARITAL STATUS: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

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

MEDICAL INFORMATION:

FATHER: [ ] Living [ ] Deceased Medical Problems:_____

MOTHER: [ ] Living [ ] Deceased Medical Problems:_____

SIBLINGS: [ ] Living [ ] Deceased Medical Problems:_____

FAMILY PHYSICIAN:_____**Phone:**_____

MEDICATIONS:_____

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

PAST MEDICAL HISTORY:

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