

SOUTHWEST FOOT INSTITUTE

DR MICHAEL DERSHOWITZ

DR GREG LOO

DR GREGG KRAHN

Patient _____ Date ____/____/____

Home Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ ext _____

Email _____ Fax Phone (____) _____

Social Security # _____ Date of Birth ____/____/____

Age _____ Sex: Male _____ Female _____ Marital Status: S _____ M _____ W _____ D _____

Primary or Referring Physician _____ Phone (____) _____

Patient Employer _____ Occupation _____

Primary Insurance Company _____

ID or Policy # _____ Group # _____

Are you the Policy Holder? _____ If not, please note who is _____

Policy Holder relationship to patient _____ DOB: ____/____/____

Secondary Insurance Company _____

ID or Policy # _____ Group # _____

Are you the Policy Holder? _____ If not, please note who is _____

Policy Holder relationship to patient _____ DOB: ____/____/____

IT IS YOUR RESPONSIBILITY TO INFORM US OF ANY CHANGES IN YOUR INSURANCE. FAILURE IN DOING SO MAY RESULT IN CLAIMS NOT BEING PAID AND YOU BEING BILLED FOR THE ENTIRE BALANCE.

A FEE OF 33 % TO 50% WILL BE ADDED TO UNPAID BALANCES THAT REQUIRE COLLECTION AND/OR LEGAL SERVICES.

I, the undersigned, certify that I (or my dependant) have insurance coverage with the above plan(s) and hereby assign all insurance benefits, if any, otherwise payable to me, directly to **SOUTHWEST FOOT INSTITUTE** for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I also authorize the doctor to release all information necessary to secure the payment of benefits from my insurance company.

Responsible Party Signature _____ Date ____/____/____

PATIENT _____ AGE _____ DATE ____/____/____

SHOE SIZE _____ WEIGHT _____ HEIGHT _____

MEDICAL HISTORY Please mark all that apply

- DIABETIC
- HYPERTENSION
- HEART DISEASE
- LUNG DISEASE
- LIVER DISEASE
- INFECTIOUS DISEASE
- ARTHRITIS
- HEPATITIS
- GOUT

ALLERGIES Please mark all that apply

- NONE
- ASPIRIN
- PENICILLIN
- SULFA
- IODINE
- CODIENE
- CORTISONE
- TAPE
- GLOVES
- OTHER _____

CURRENT MEDICATIONS

PAST SURGERIES (past 10 years)

- | | |
|----------|----------|
| 1. _____ | 1. _____ |
| 2. _____ | 2. _____ |
| 3. _____ | 3. _____ |
| 4. _____ | 4. _____ |
| 5. _____ | 5. _____ |

What foot/ankle problem brought you to our office today? _____

How long has this problem been present? _____

Have you had any treatment? _____

If yes, who performed the treatment? _____

Is the problem the result of an injury? Yes _____ No _____

If yes, what is the date of injury? ____/____/____

Where did the injury occur? _____

If the injury occurred at work, has your employer been notified? _____