

MICHAEL H. GOLF, D.P.M., P.C.

-PATIENT INFORMATION SHEET-

(Mr., Mrs., Ms.) Last Name: _____ Middle Initial: _____ First Name: _____
Preferred Name: _____ Social Security #: _____
Street: _____ City: _____ State: _____ Zip: _____
Home Tel.: () _____ Bus. Tel.: () _____ Ext.: _____
Date of Birth: ____/____/____ Age _____ Sex: Male Female Marital Status: Single Married Widowed
Employer: _____ Full Time Part Time Retired Not
Student: Full Time Part Time Not School Name/Address _____
Emergency Contact Name: _____ Telephone: _____
Family Physician: _____ Referred by: _____
If accident, was injury related to patient's employment? Yes No Auto Accident? Yes No

MEDICAL INSURANCE

All fees are due at the time of service.

If we are providers of your insurance plan, please present your insurance card.

PRIMARY INSURANCE

Insurance Company Name _____

Address _____

Phone #() _____

Policy # _____

Plan/Group # _____

Name of Insured _____

(Policyholder)

Insured's Address _____

Insured's

Phone (Home) _____ (Work) _____

Insured's Date of Birth ____/____/____

Insured's SS# ____/____/____

Insured's Employer _____

Patient's Relation to Insured: Self Spouse Child Other

SECONDARY INSURANCE

Insurance Company Name _____

Address _____

Phone #() _____

Policy # _____

Plan/Group # _____

Name of Insured _____

(Policyholder)

Insured's Address _____

Insured's

Phone (Home) _____ (Work) _____

Insured's Date of Birth ____/____/____

Insured's SS# ____/____/____

Insured's Employer _____

Patient's Relation to Insured: Self Spouse Child Other

I authorize the release of any medical information necessary to process this claim and authorize payment of medical benefits to Michael H. Golf, D.P.M., P.C. for services. I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered.

Insured's Signature _____ Date: _____

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? Y N
 a. Height _____ b. Weight _____
2. Do you use:
 a. Tobacco Y N
 b. Alcohol Y N
 c. Drugs Y N
3. Do you have or have you ever had:
 a. Asthma Y N
 b. Rheumatic fever Y N
 c. Anemia Y N
 d. Thyroid trouble Y N
 e. Glaucoma Y N
 f. Kidney disease Y N
 g. Ulcers (stomach or duodenal) Y N
 h. Bleeding problems Y N
4. Has there been any change in your general health within the past year? ... Y N
5. My last physical examination was on _____
6. Are you now under the care of a physician? Y N
 If so, what is the condition being treated? _____

7. Have you had any serious illness or operation in the last 5 years? Y N
 If so, what was the illness or operation?

8. If so, did you have trouble from the anesthesia? Y N
9. Do you have or have you had any of the following diseases or problems?
 a. Damaged heart valves or artificial heart valves, including heart murmur Y N
 b. Cardiovascular disease (heart trouble, heart attack, high blood pressure, stroke) Y N
 1. Do you have pain in chest upon exertion? Y N
 2. Are you ever short of breath? .. Y N
 3. Do your ankles swell? Y N
 4. Do you have a cardiac pacer-maker? Y N
- c. Allergy Y N
 d. Sinus trouble Y N
 e. Hay fever Y N
 f. Hives or a skin rash Y N
 g. Fainting spells or seizures Y N
 h. Diabetes Y N
 i. Hepatitis, jaundice or liver disease Y N
 j. Arthritis Y N
 k. Stomach ulcers Y N
 l. Kidney trouble Y N
 m. Tuberculosis Y N
 n. Do you have a persistent cough or cough up blood Y N
 o. Low blood pressure Y N
 p. Venereal disease Y N
 q. Epilepsy Y N
 r. Psychiatric problems Y N
 s. Cancer Y N
 t. Other Y N
10. Have you been tested for acquired immune deficiency syndrome (AIDS) Y N
 If so, negative or positive N P
11. Have you had abnormal bleeding associated with surgery or trauma? .. Y N
 a. Do you bruise easily? Y N
 b. Have you ever required a blood transfusion? Y N
 If so, explain the circumstances

12. Have you ever taken drugs for epilepsy, psychiatric therapy, or blood clots? Y N
13. Have you taken steroids (cortisone, prednisone, etc.) in the last two years? Y N
14. Are you currently taking any medication? Y N
 a. Anticoagulants Y N
 b. Tranquilizers Y N
 c. Cortisone Y N
 d. Other medications? (please list) ... Y N

15. Are you allergic or have you reacted adversely to:
 a. Local anesthetics Y N
 b. Penicillin Y N
 c. Other antibiotics (please list) Y N
 d. Sulfa drugs Y N
 e. Barbiturates, sedatives, or sleeping pills Y N
 f. Aspirin Y N
 g. Iodine Y N
 h. Codeine or other narcotics Y N
 i. Other Y N

16. Do you have disease, condition, or problem not listed above that you think I should know about? Y N
 If so, explain _____

17. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? Y N

Women

18. Are you pregnant? Y N
19. Do you have any problems associated with your menstrual period? Y N
20. Are you nursing? Y N
21. Do you take birth control pills? Y N

Chief Podiatric Complaint

I certify that I have read and understand the above, I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my podiatrist or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient

Signature of Surgeon