



Advantage Foot Care

MEDICAL INFORMATION

1. PATIENT INFORMATION

NAME: _____ SEX: M F HOME PHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ WORK PHONE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY # _____

MARITAL STATUS: _____ SPOUSE/PARENT NAME: _____

FAMILY PHYSICIAN: _____ CITY LOCATED IN: _____

HOW DID YOU HERE ABOUT OUR OFFICE: _____

2. INSURANCE INFORMATION

(If you have your insurance care with you please bring it up to the desk to be photocopied)

INSURANCE NAME #1: _____ PHONE NUMBER: _____

ADDRESS: _____

GROUP NUMBER: _____ POLICY NUMBER: _____

SUBSCRIBER: _____ RELATIONSHIP: _____ DOB: _____

INSURANCE NAME #2: _____ PHONE NUMBER: _____

ADDRESS: _____

GROUP NUMBER: _____ POLICY NUMBER: _____

SUBSCRIBER: _____ RELATIONSHIP: _____ DOB: _____

3. ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED CERTIFY THAT I HAVE INSURANCE COVERAGE WITH THE ABOVE LISTED INSURANCE AND I ASSIGN DIRECTLY TO DR. EDWARD P. NEWCOTT ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY THE INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL SUBMISSIONS.

PATIENT SIGNATURE

DATE

THE PATIENT IS RESPONSIBLE FOR OBTAINING REFERRALS FOR SERVICES!

MEDICAL INFORMATION CON'T

4. MEDICAL HISTORY

HAVE YOU BEEN UNDER THE CARE OF A MEDICAL DR. DURING THE LAST TWO YEARS? _____

PHYSICIAN'S NAME: _____ REASON: _____

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> DIABETES | <input type="checkbox"/> PSYCHIATRIC CARE |
| <input type="checkbox"/> ALLERGIES TO ANTIHISTAMINES | <input type="checkbox"/> EAR PROBLEMS | <input type="checkbox"/> RADIATION TREATMENT |
| <input type="checkbox"/> ALLERGIES TO MEDS/DRUGS | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> RASH |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> EYE PROBLEMS | <input type="checkbox"/> RESPIRATORY DISEASE |
| <input type="checkbox"/> ANGINA | <input type="checkbox"/> FAINTING | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> LEG CRAMP | <input type="checkbox"/> SHORTNESS OF BREATH |
| <input type="checkbox"/> ARTIFICIAL JOINTS/VALVE | <input type="checkbox"/> GOUT | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> BACK PROBLEMS | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> SPECIAL DIET |
| <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> HEPATITIS/JAUNDICE | <input type="checkbox"/> SWELLING ANKLES/FEET |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> TIRED FEET |
| <input type="checkbox"/> CHEMICAL DEPENDENCE | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> CHEST PAIN/CARDIAC PROBLEM | <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> CHRONIC DIARRHEA | <input type="checkbox"/> NERVOUS CONDITION | <input type="checkbox"/> VENEREAL DISEASE |
| <input type="checkbox"/> CIRCULATORY PROBLEMS | <input type="checkbox"/> PHLEBITIS | <input type="checkbox"/> WEIGHT LOSS |

OTHER CONDITION NOT LISTED: _____

SURGERIES YOU HAVE HAD:

YEAR:

_____	_____
_____	_____
_____	_____

HOSPITALIZATION OTHER THAN SURGERIES LISTED:

YEAR:

_____	_____
_____	_____

ALLERGIES:

MEDICATIONS:

_____	_____
_____	_____
_____	_____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE

DATE