DATE: _____/_____/_____

PATIENT NAME:_____ **AGE** _____ **DATE OF BIRTH** _____/_____/_____

MALE ( ) FEMALE ( ) Are you pregnant? (Y) (N)

PRIMARY PHYSICIAN: _____ **PHYSICIAN'S PHONE** _____-_____-_____
PHYSICIANS ADDRESS:_____
_____

Date you last saw your primary care physician _____/_____/_____

HOW DID YOU FIND OUT ABOUT OUR OFFICE? (SELF) (DOCTOR) (PHONE BOOK) (FRIEND) (OFFICE SIGN) (WEB SITE) OTHER_____)

EMERGENCY CONTACT:_____ **PHONE** _____

RELATIONSHIP_____
****

WHAT IS YOUR FOOT PROBLEM? _____

****

PATIENT'S MEDICAL HISTORY: (Circle any that may apply)
DIABETES HIGH BLOOD PRESSURE HEART DISEASE HEART VALVE PROBLEM
HEART ATTACK STROKE GOUT KIDNEY DISEASE ASTHMA EMPHYSEMA
COPD CANCER ARTHRITIS SEIZURES DEEP VEIN THROMBOSIS (Blood Clot)
STOMACH ULCER BLEEDER TUBERCULOSIS HEPATITIS IMMUNE DISORDER
OTHER:_____

PAST SURGICAL HISTORY:_____
_____
_____

FAMILY MEMBER'S MEDICAL HISTORY: (HEREDITARY) (Parents, grandparents, siblings)
_____
_____

CURRENT MEDICATIONS:
_____
_____
_____

ALLERGIES: (NONE) PENICILLIN SULFA ASPIRIN LATEX CODEINE IODINE
ADHESIVE TAPE LOCAL ANESTHETICS 0THER_____

Do you drink alcohol: (NO) Mild Consumption Moderate Consumption Heavy Consumption

Do you smoke cigarettes? (NO) (½ pack/day) (1 pack/ day) (more than 1 pack/day) (Previous use)

PERSONAL AND INSURANCE INFORMATION:

PATIENT'S NAME:_____ **PATIENTS DATE OF BIRTH:** ____/____/____

PATIENT'S SOCIAL SECURITY NUMBER ____-____-____ **(Please provide a photo identification)**

PATIENT'S ADDRESS: Street: _____
_____ **(Apt. or Lot #**____**)**
(If a post office box, you must also provide a physical address.)

City: _____ **State:** _____ **Zip Code:** _____ - _____

HOME PHONE ____-____-_____ **CELL PHONE** ____-____-_____

E-MAIL _____@_____

PATIENT'S OCCUPATION: _____ **EMPLOYER**_____
****

WHAT IS YOUR INSURANCE?_____
(Please provide your insurance card(s))

SUBSCRIBER'S NAME_____ **Subscribers Date of Birth**____/____/____

PATIENT'S RELATIONSHIP TO INSURANCE SUBSCRIBER: (SELF) (SPOUSE) (CHILD)
(If different than above)
SUBSCRIBER'S ADDRESS: Street: _____
_____ **(Apt. or Lot #** ____**)**
(If a post office box, you must also provide a physical address)
City: _____ **State:** _____ **Zip Code:** _____ - _____

Home Phone ____-____-_____ **Cell Phone** ____-____-_____

****

STATEMENT TO AUTHORIZE PAYMENT OF MEDICARE BENEFITS

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or it's carrier's, any information required to process my Medicare claims. I request that payment under the medical insurance program be made to Dr. Harry Zirna for services provided to me during the period from: (present to indefinite).

_____ **Date:** _____
Medicare Beneficiary Signature
****

PRIVATE HEALTH INSURANCE COVERAGE PATIENT AGREEMENT

I affirm that my recorded medical history accurately reflects my present medical health. Furthermore, I consent to evaluation and treatment by Dr. Harry Zirna. I also understand that my health insurance is a contract between myself and my insurance company. If a delivered professional service or an orthotic device is rejected or denied by my insurance company, I understand that I am ultimately responsible for payment.

_____
Patient's signature (or parent or legal guardian's signature)

PHARMACY (Name, address, phone) :