Today's Date:_____________

Name: ____ SSN: ______-_____-______
First MI Last

Address: ____
Street City State Zip

Date of Birth: ____/____/____ Age: ____ Female Male Marital Status: S M W D

Home Phone: (_____)______-_________ Work Phone: (_____)______-________

Spouse's Name: _________________________ Cell Phone: (____)_____-_____________

Emergency Contact: _______________________ Phone: (____)_____-______________

Email: ____

Employer Name and Occupation: ____

Family Doctor: ___________________________________ Date of last visit:_______________

Preferred Pharmacy: ______________________________ Location: ____________________

Previous Podiatrist: _______________________________ Date of last visit:_______________

How did you hear about us?

Website Phone book Location/Sign Insurance Reputation

Friend/Family __________________ Physician ___________________

Insurance Information

Primary Insurance: ____

Name of Insured: ____

Relation to Patient: __________________ Insured date of birth: ____/____/____

Employer Name: _________________________________

Medical Information

Current Medications:

____

____

List any medications you are allergic to: ____________________________________

List any surgeries you have had: ____

Do you currently have or have you had any of the following? (Please Circle One)

Condition				Condition			
Diabetes	Yes	No	Unknown	Fainting Spells	Yes	No	Unknown
Heart Trouble	Yes	No	Unknown	Bleeder	Yes	No	Unknown
Liver Disease	Yes	No	Unknown	Blood Disease	Yes	No	Unknown
Kidney Disease	Yes	No	Unknown	Circulation Problems	Yes	No	Unknown
Rheumatic Fever	Yes	No	Unknown	Hardening of Arteries	Yes	No	Unknown
High Blood Pressure	Yes	No	Unknown	Varicose Veins	Yes	No	Unknown
Stomach Ulcers	Yes	No	Unknown	Arthritis	Yes	No	Unknown
Asthma/Emphysema	Yes	No	Unknown	Cancer	Yes	No	Unknown
Anemia	Yes	No	Unknown	Prone to Infection	Yes	No	Unknown
Gout	Yes	No	Unknown	Stroke	Yes	No	Unknown
Thyroid Problems	Yes	No	Unknown	High Cholesterol	Yes	No	Unknown
Consume Alcohol	_____ Drinks per day			Smoker	Current	Never	Quit ___ Yrs

List any other medical conditions you have or have had:

____

____

My chief foot complaint is:

____

____

I understand and agree that, regardless of my insurance policy, I am responsible for the entire balance on my account, for all professional services provided to the patient. I certify that, to the best of my knowledge, this information is correct and true. I will notify this office in case of any changes to my health or any of the above information.

Patient's (Or Guardian's) Signature: ______________________________ **Date:** ___________

Release of Medical Information

I authorize the release of any medical information necessary to process my insurance claim.

____ Date: ____________
Authorized Signature

Authorization of Payment

I authorize payment of medical benefits to Dr. William Bushnell for services rendered.

____ Date: ____________
Authorized Signature

Acknowledgment of Receipt of Notice of Privacy Practices

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.

____ Date: ____________
Authorized Signature