

Leslie G. Levy, D.P.M., F.A.C.F.S.
Dana Lavian, D.P.M., F.A.C.F.S.

DATE _____

B.P. _____

Welcome To Our Office

Please print: The following information is important. Your cooperation is appreciated.

Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/>		LAST NAME	FIRST	MIDDLE	AGE	BIRTHDATE	SOCIAL SECURITY NO.				
HOME ADDRESS				CITY	STATE	ZIP CODE	HOME PHONE NO. ()				
EMPLOYER		OCCUPATION		HOW LONG EMPLOYED ()	BUSINESS PHONE NO.		DRIVER'S LICENSE NO.				
EMPLOYER'S ADDRESS				CITY	STATE	ZIP CODE	MARITAL STATUS				
							S	M	W	D	Sep.
SPOUSE'S NAME					AGE	BIRTHDATE	SOCIAL SECURITY NO.				
SPOUSE'S EMPLOYER			OCCUPATION		HOW LONG EMPLOYED ()	BUSINESS PHONE NO.		DRIVER'S LICENSE NO.			
EMPLOYER'S ADDRESS				CITY	STATE	ZIP CODE	NUMBER OF CHILDREN and AGES				
NAME, ADDRESS and PHONE NO. OF CONTACT, IN CASE OF EMERGENCY								RELATIONSHIP			

DO YOU HAVE MEDICAL INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	CARRIER NAME	SUBSCRIBER NAME	POLICY NO.	GROUP NO.
WHAT PERCENTAGE OF USUAL, CUSTOMARY AND REASONABLE FEES ARE PAID?	<input type="checkbox"/> 70 <input type="checkbox"/> 80 <input type="checkbox"/> 90 <input type="checkbox"/> 75 <input type="checkbox"/> 85 <input type="checkbox"/> 100		WHAT IS YOUR DEDUCTIBLE?	HOW MUCH IS MET THIS YEAR?
IS THERE SECONDARY INSURANCE? (SPOUSE, SUPPLEMENTAL)	CARRIER NAME	SUBSCRIBER NAME	POLICY NO.	GROUP NO.
NAME OF MEDICAL DOCTOR	ADDRESS			DATE OF LAST EXAM.

RESULTS	HEIGHT	WEIGHT	SHOE SIZE
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I AM ALLERGIC TO: NOVOCAINE ANTIBIOTICS ASPIRIN FOODS
 PENICILLIN CODEINE TAPE NONE OTHERS:

WHAT MEDICINES ARE YOU NOW TAKING?

PREVIOUS OPERATIONS and DATES:

SERIOUS ACCIDENTS OR DISABILITIES and DATES

MY CHIEF FOOT and ANKLE COMPLAINT IS:

Do you have or have you had any of the following:

	YES	NO		YES	NO		YES	NO			
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Thrombophlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>
Typhoid	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Foot or Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>	Severe Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Breakdown	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Suicide Attempt	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Severe Infections	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhoea	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

I hereby give my permission to Dr. **Leslie Levy** and his staff to administer treatment and medications and to perform such procedures as may be deemed necessary or advisable in the diagnosis and/or treatment, AND TO NOTIFY MY PHYSICIAN OF SUCH. I understand that I am responsible for any fees, regardless of insurance coverage, and that it is customary to pay for all professional services on the date they are rendered, unless other arrangements have been made. I have received a copy of office policy brochure.

SIGNATURE _____