(661) 254-0795
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Leslie G. Levy, D.P.M., F.A.C.F.S.
Dana Lavian, D.P.M., F.A.C.F.S.

_____

DATE _____

Welcome To Our Office

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

LAST NAME	FIRST	MIDDLE	AGE	BIRTHDATE	SOCIAL SECURITY NO.

HOME ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE NO.
				( )

RESPONSIBLE PARENT/GUARDIAN	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 OR PARENT	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? ☐ YES ☐ NO	CARRIER NAME	SUBSCRIBER NAME	POLICY NO.	GROUP NO.

WHAT PERCENTAGE OF USUAL, CUSTOMARY AND REASONABLE FEES ARE PAID? ☐ 70 ☐ 75 ☐ 80 ☐ 85 ☐ 90 ☐ 100	WHAT IS YOUR DEDUCTIBLE?	HOW MUCH IS MET THIS YEAR?

IS THERE SECONDARY INSURANCE? (SPOUSE, SUPLEMENTAL)	CARRIER NAME	SUBSCRIBER NAME	POLICY NO.	GROUP NO.

NAME OF MEDICAL DOCTOR	ADDRESS	DATE OF LAST EXAM.

RESULTS	HEIGHT	WEIGHT	SHOE SIZE

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

I hereby give my permission to Dr. 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. I am responsible for all my child's medical bills incurred.

_____
SIGNATURE OF PARENT OR GUARDIAN

REFERRED BY _____