

PATIENT INFORMATION

Name _____ SSN# _____

Date _____ Birth Date _____ Age _____

Address _____ Apt. _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

E-mail address: _____

Employer _____ Employer Address _____

City _____ State _____ Zip Code _____ Driver's License# _____

Work Phone _____ Occupation _____

(Circle one) Single Married Separated Divorced Widowed

Name of Spouse (Parent if Minor) _____

Spouse's/Parent's Occupation _____

Spouse's/Parent's Employer _____ Work Phone _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____ Phone Number _____

Relationship _____ (If patient is a minor: name of parent, guardian, etc.)

HEALTH INSURANCE INFORMATION

PLEASE READ AND SIGN

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other patient responsible balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH THE DOCTOR.

If this account is assigned for collection and/or suit, collection costs and/or attorneys fess, and/or court cost will be added to the total amount due.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

I hereby assign all medical and / or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medical, private insurance, and other health plans to: Mafutaga Tagaloa-Tulifau, D.P.M.

Signature _____ Date _____

HEALTH INSURANCE INFORMATION

Name of Insurance Company _____ ID# _____

Policy Holder _____ Group # _____

Name of Co-Insurance _____ ID# _____

Policy _____ Group # _____

HEALTH INFORMATION

Please describe your foot or ankle problem: _____

How long has it bothered you? _____ Wk/mo/yr (circle one)

Have you seen another doctor? YES NO

Patients Primary Physician: _____

Address _____ City _____ State _____ Zip _____

Date of last EKG: _____ Date of last chest X-ray _____

Weight: _____ Shoes Size: _____

Are you in good health? YES / NO

Are you now (or have been in the last two years) under the
Care of a physician for a chronic illness? YES / NO

Have you ever been hospitalized or had an operation?
If YES, please describe: _____ YES / NO

Have you ever experienced any side effects from Novocaine?
Penicillin, Codeine or any other drug? YES / NO

Do you have any allergies?
If YES, please list: _____ YES / NO

Are you presently taking any medications?
If YES, please list: _____ YES / NO

Female Patients: Are you pregnant or plan to be in the near future? YES / NO

Have you ever had any injuries, broken bones, or operations in
your feet, ankles, or legs? YES / NO
If YES, please describe: _____

**Have you ever been treated for any of the following?
(Please circle YES or NO)**

Asthma	YES / NO	Anemia	YES / NO
Arthritis	YES / NO	Back Problems	YES / NO
Blood Clots	YES / NO	Bronchitis	YES / NO
Cancer	YES / NO	Diabetes	YES / NO
Emphysema	YES / NO	Heart Trouble	YES / NO
Hepatitis	YES / NO	High Blood Pressure	YES / NO
HIV Infection	YES / NO	Kidney Problems	YES / NO
Tuberculosis	YES / NO	Pneumonia	YES / NO
Liver Problems	YES / NO	Seizures	YES / NO
Rheumatic Fever	YES / NO	Ulcers	YES / NO

Is there ANY OTHER important information about YOUR HEALTH? YES / NO

If yes, please describe: _____

Does anyone you know have an ankle, heel, foot or problem, which they are not taking care of right now and whom you'd like to see get relief? Please state their name, address and type of problem below. We will contact them.

Name _____ Relationship to you _____

Address _____

Phone Number _____

Who may we thank for referring you to our office?

Name _____

Address _____

Phone Number _____

Do you have access to the Internet?

Please visit us at www.doctortulifau.com