DATE: ____/____/____

PATIENT NAME: _______________________________ DATE OF BIRTH: ____/____/____ AGE: _____ SEX: M F

HOME ADDRESS: ___________________________ CITY/STATE: _________________________ ZIP: ____________

HOME PHONE #: (___) ____-_____ CELL PHONE #: (___) ____-_____ E-MAIL- ________________________

SOCIAL SECURITY NUMBER: _______________________________

PRIMARY CARE DOCTOR NAME: ____

DOCTOR'S PHONE/ADDRESS: ____

PRIMARY LANGUAGE: _____________________________ ETHNICITY: ____________________________________

PHARMACY: ______________________________ LOCATION: __________________ __PHONE #: (___) ____-_____

INSURANCE INFORMATION

INSURED NAME: _________________________ DATE OF BIRTH ____________ EMPLOYER ___________________

PRIMARY INSURANCE COMPANY NAME: ____

ADDRESS: _____________________ CITY/STATE: ______________ ZIP: __________ PHONE #: (___) ____-_____

CONTRACT # _________________________________ GROUP # ____

SECONDARY INSURANCE COMPANY NAME: ____

ADDRESS: _____________________ CITY/STATE: ______________ ZIP: __________ PHONE #: (___) ____-______

CONTRACT # _____________________________________ GROUP # _____________________________________

PATIENT HISTORY

ALLERGIES: [ ] NONE KNOWN

[ ] MEDICATION ALLERGIES:

CODEINE ANTICOAGULANTS DEMEROL SULFA ASPIRIN IODINE PENICILLIN

OTHERS: ____

[ ] ANESTHESIA ALLERGIES ___________________________

[ ] FOOD ALLERGIES ____

OTHER____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE FREQUENCY

CAN WE LEAVE MESSAGES AT ANY OF THE ABOVE LISTED NUMBERS? YES [ ] NO [ ]

EMERGENCY CONTACT NAME: ________________________________RELATIONSHIP:_______________

PHONE NUMBER:_________________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CHECK)

[ ] **BLEEDING DISORDER**	[ ] **CANCER**	[ ] **LIVER DISEASE**	[ ]**LOW BLOODPRESSURE**
[ ] **ANKLE PAIN**	[ ] **DIABETES**	[ ] **ATHLETE'S FOOT**	[ ] **FAINTING**
[ ] **ANEMIA**	[ ] **FIBROMYALGIA**	[ ] **MIGRAINES**	[ ] **STOMACH ULCERS**
[ ] **ARTHRITIS**	[ ] **GOUT**	[ ] **HEEL PAIN**	[ ] **STROKE**
[ ] **ASTHMA**	[ ] **HEART ATTACK**	[ ] **NEUROPATHY**	[ ] **THYROID DISEASE**
[ ] **BACK TROUBLE**	[ ] **HEART DISEASE**	[ ] **FLAT FEET**	[ ] **TUBERCULOSIS**
[ ] **INGROWN TOENAILS**	[ ] **HEPATITIS**	[ ] **DEPRESSION**	[ ] **OSTEOPOROSIS**
[ ] **HIV/AIDS**	[ ] **SEIZURE DISORDER**	[ ] **CHEST PAIN**	[ ] **VENEREAL DISEASE**
[ ] **HIGH BLOOD PRESSURE**	[ ] **RHEUMATIC FEVER**	[ ] **SWOLLEN FEET**	[ ] **KIDNEY DISEASE**

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE

____

____

SOCIAL HISTORY:

TOBACCO USE: [ ] NEVER [ ] FORMER [ ] SOMETIME [ ] EVERYDAY

ALCHOL DEPENDENCY: [ ] YES [ ]NO

SHOE SIZE:____________________**WEIGHT:**_____________________**HEIGHT**:_____________________

I certify that the above and attached information is true and correct to the best of my knowledge. I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I understand the policy. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary to the diagnosis and/or treatment of me or my child's condition. As a representative of myself or as a guardian, I give authorization for the above listed person to receive medical and/or surgical care and treatment with Mitchell Wachtel DPM.

Printed Patient's Name:______________________________

Representative's Signature:__________________________ Date:_____