INFORMATION FOR DR. PREUSS

DATE

NAME ADDRESS

SOCIAL SECURITY # CITY STATE ZIP

HOME # / WORK #	DATE OF BIRTH	AGE	SEX	MARITAL STATUS (please circle)
			M___ F___	Mar. Sin. Wid. Div. Sep.

CELL # EMAIL ADDRESS:

EMPLOYER NAME, ADDRESS

NAME, ADDRESS, AND TELEPHONE # OF SPOUSE OR PARENT D.O.B. SOCIAL SECURITY #

EMPLOYER OF SPOUSE (name, address, & telephone number)

NAME & TELEPHONE # OF NEAREST RELATIVE NOT LIVING AT YOUR ADDRESS

HOW DID YOU HEAR ABOUT US? Name and Address

PRIMARY CARE DOCTOR'S NAME:

HEALTH INFORMATION

Describe your foot problem or complaint:

How long have you had this condition? What previous treatment have you had?

Are you in good health? YES____ NO_____

Are you under a doctor's care? YES____ NO_____ For What?

Are you taking any medications? YES____ NO_____ What Kinds?

Are you allergic to? Novocain Penicillin Sulfa Aspirin Codeine Adhesive Tape Latex

(Please circle those that apply) Others

CIRCLE ANY ILLNESSES/CONDITIONS YOU HAVE HAD:

Diabetes	Glaucoma	High blood pressure			
Heart trouble	Vein trouble	Cancer	Asthma	Bleeding tendencies	Tuberculosis
Pneumonia	Kidney trouble	Stroke	Arthritis	Rheumatic fever	Epilepsy
Nervous disorder	HIV	Other (please list)_____			

IS THERE A FAMILY HISTORY FOR ANY OF THE ABOVE ILLNESSES OR DISEASES? YES ___ NO ___

WHICH FAMILY MEMBER AND WHAT DISEASE:

HAVE YOU HAD ANY OPERATIONS? YES ___ NO ___ (Please list types and dates)

HAVE YOU EVER HAD - Foot surgery X-rays Other

DO YOU USE TOBACCO NOW? YES ___ NO ___

IN THE PAST? YES ___ NO ___ AMOUNT

DO YOU USE ALCOHOLIC BEVERAGES? YES ___ NO ___

TYPE AMOUNT

HEIGHT WEIGHT SHOE SIZE HAVE YOU HAD ANY SERIOUS INJURIES, BROKEN BONES, ETC.?

PERMISSION FOR TREATMENT: I hereby give permission to H. Fred Preuss, Jr., DPM to administer treatment and to perform such treatment procedures as may be deemed necessary in the diagnosis and treatment of my foot condition.

SIGNATURE _____ DATE _____

AUTHORIZATION FOR ASSIGNMENT OF INSURANCE PAYMENT AND RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of medical information such as may be necessary to expedite this claim. I hereby authorize my insurance company to pay directly to Dr. H. Fred Preuss, Jr. the insurance benefits and/or major medical benefits that are due and payable under this insurance policy. I understand that I am responsible for charges not included or not covered by the insurance payment. I understand that Dr. Preuss has a minority ownership in the hospital Physicians Medical center. He is proud of the quality of care that this facility provides.

SIGNATURE _____

PLEASE GIVE YOUR INSURANCE ID CARD TO RECEPTIONIST AND SHE WILL COPY IT FOR OUR RECORDS