“Welcome to our office”

MARC HASPEL, DPM
Podiatric Medicine and Surgery
Diplomate, American Board of Podiatric Orthopedics
& Primary Podiatric Medicine
Diplomate, American Board of Podiatric Surgery

Name___________________________________ Date ______________________
Address ___________________________ Home Phone: _____________________
___________________________________ Work Phone: _____________________
E-Mail address________________ Who Referred You? _____________________
Social Security # __________________ Emergency Contact___________________
Date of Birth: ______________ Birth Place: _____________________M___F___
Name of Family Physicians: ____
Address of Physician: ____
Date Last Seen: _______________ How is Your Health? ___Good ___ Fair ___Poor
Are You Taking Any Medications Now? ______Yes _____ No
If Yes, What? ____
PLEASE INDICATE IF YOU HAVE OR HAVE ANY OF THE FOLLOWING
diabetes ___ skin diseases or problems___ high blood pressure___ nerve problems ___
heart problems ___ venereal disease___ rheumatic fever___ blood disease___
lung problems___ epilepsy___ liver problems___ arthritis or bursitis___
intestinal problems___ circulation problems___ ulcers___ phlebitis/varicose veins___
kidney problems___ prolonged bleeding ___ difficulty in healing ___ bone problems ___
scar formation ___ fractures ___ swelling ___ psychiatric problems ___ pregnancy___
fainting ___ previous surgery________________ hospitalization____________________
allergies_________________________________ other ___________________________

Are you allergic to any medications? ___ Yes ___ No
If so, what? ____
What is your present foot problem? ____
How long has it bothered you? ____
Have you had previous care by a Podiatrist? ____________________________________
What is your weight? _________ Height? _____________ Shoe size ________________
Do you have a current or former smoking history?
____
What is your occupation? ____
Please list any regular activity____

I hereby give Dr. Haspel permission to examine my feet and to perform such procedures in the diagnosis and treatment of my condition. I will inform the doctor of any changes in my health and medications. I authorize the release of my medical information for insurance purposes. I agree that I am ultimately responsible for payment for services rendered by Dr. Haspel. I agree that Dr. Haspel retain my X-ray as part of his records. I agree that there is no guarantee concerning my treatment results.

Signature: ____
Date:_______________________
Signature of Legal Guardian: ________________________________ Date: ______________
Insurance Company:
____
Spouse’s Insurance:
____