B.P. _____

THOMAS NEUMAN, D.P.M., F.A.A.F.S.

Diseases and Surgery of the Foot, Ankle, and Leg

EMAIL _____

DATE _____

Welcome To Our Office

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

MR. ☐ MRS. ☐ MISS ☐ LAST NAME	FIRST	MIDDLE	AGE	BIRTHDATE	SOCIAL SECURITY NO.
HOME ADDRESS	APT./ SP. NO.	CITY	STATE	ZIP CODE	HOME PHONE NO. ( )
EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	BUSINESS PHONE NO. ( )		CELL PHONE NO. ( )
EMPLOYER'S ADDRESS	CITY		STATE	ZIP CODE	MARITAL STATUS S M W D SEP.
SPOUSE'S NAME			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 NUMBER	GROUP NO.
WHAT PERCENTAGE OF USUAL, CUSTOMARY AND REASONABLE FEES ARE PAID? ☐ 70 ☐ 80 ☐ 90 ☐ 75 ☐ 85 ☐ 100			WHAT IS YOUR DEDUCTIBLE?	HOW MUCH IS MET THIS YEAR?
IS THERE SECONDARY INSURANCE? (SPOUSE, SUPPLEMENTAL)	CARRIER NAME	SUBSCRIBER NAME	POLICY NUMBER	GROUP NO.

NAME OF PRIMARY CARE DOCTOR	ADDRESS & PHONE NO.	DATE OF LAST EXAM

RESULTS OF LAST EXAM	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 / ANKLE COMPLAINT IS:

Do you have or have you had any of the following:

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

I hereby give my permission to **Dr. Thomas Neuman** 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 the office policy brochure.

SIGNATURE _____

REFERRED BY _____

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