# PLEASE PRINT

**Welcome To Our Office** **BRUCE D. LEVINE, D.P.M.**

*Harbor Foot and Ankle Podiatric Medical Group*

*****FILL IN PARENT/GUARDIAN INFORMATION IN HIGHLIGHTED AREA IF PATIENT IS A MINOR*****

| | | | | | |
|---|---|---|---|---|---|
| Last Name | First | | Middle Initial | | Today's Date |
| Residence Address | City | State | Zip Code | Date of Birth | Age |
| Home Phone Number | Alternate Phone Number | | Email Address: | | |
| Social Security Number | Spouse's Name, Parent's or Guardian's Name if Minor | | | | Marital Status: |
| Name of Patient's Employer | Occupation | | | | Business Phone Number |
| Whom May We Thank for Referring You? | Name of Person to Contact in Case of Emergency | | | | Phone number of Emergency Contact |
| Do You Have Medical Insurance? | Name of Insurance Carrier | | | Subscriber Name | |
| Group Number | Policy Number | Subscriber Date of Birth | | | Do You Have A Deductible?<br>Have You Met It For This Year? |
| Do You Have A Secondary Insurance? | Name of Insurance Carrier | | | Subscriber Name | |
| List any Medical Conditions You Have (allergies, impairments, etc) | | | | | |
| Name of Your Medical Doctor | | | Are you Currently Under Your Physician's Care? | | |
| If Yes For What? | When Did you last see Your Doctor? | | May We Contact Your Physician For Your Medical Records? | | |
| Have You Had Previuos Treatment By a Podiatrist? | When? | | For What? | | Podiatrist's Name |
| My Chief Foot Complaint Is: | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| This Condition Has Existed For How Long? | Are You Pregnant At This Time? | | | | |
| What Medications Do You Currently Take? | | | | | |
| | | | | | |
| | | | | | |

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

| | | | | | | Are you allergic to: | |
|---|---|---|---|---|---|---|---|
| Foot or Leg Injuries | YES / NO | Diabetes | YES / NO | Anemia | YES / NO | Novocaine | YES / NO |
| foot or Leg Surgery | YES / NO | Heart Trouble | YES / NO | Gout | YES / NO | Penicillin | YES / NO |
| Foot or Leg Cramps | YES / NO | Epilepsy | YES / NO | Fainting Spells | YES / NO | Adhesive Tape | YES/NO |
| Foot or Leg Numbeness | YES / NO | Liver Disease | YES / NO | Bleeder | YES / NO | Materials | YES / NO |
| Knee Pain | YES / NO | Kidney Disease | YES / NO | Blood Disease | YES / NO | Drugs | YES / NO |
| Unequal Leg Length | YES / NO | Rheumatic Fever | YES / NO | Circulation Problems | YES / NO | Foods | YES / NO |
| Weak Ankles | YES / NO | High Blood Pressure | YES / NO | Hardening of Arteries | YES / NO | Latex | YES / NO |
| Bunions | YES / NO | Polio | YES / NO | Varicose Veins | YES / NO | Other | YES / NO |
| Foot Skin Problems | YES / NO | Bursitis | YES / NO | Arthritis | YES / NO | | |
| Toe Nail Problems | YES / NO | Stomach Ulcers | YES / NO | Cancer | YES / NO | | |
| Low Back Pain | YES / NO | Asthma | YES / NO | Prone To Infection | YES / NO | | |

I hereby give permission to **Bruce D. Levine, D.P.M.** to examine and treat my feet.

**Patient/ Guardian Signature**_____ **Date:**_____