BARRY A. KLEIN, DPM, FASPS, DABPS
DEBRA B. KLEIN, DPM, FASPS, DABPS

WELCOME TO OUR OFFICE

NAME_____BIRTH DATE_____ AGE___ SEX___
LAST FIRST M.I.

SOCIAL SECURITY #_____ MARITAL STATUS___S M W D_

ADDRESS_____ TOWN _____STATE _____ ZIP _____

HOME PHONE_____CELL_____WORK PHONE_____ E-MAIL_____

NAME OF EMPLOYER _____OCCUPATION _____

SPOUSE OR NEXT OF KIN_____ RELATIONSHIP_____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?_____

**********MEDICAL INFORMATION**********

REASON FOR TODAY'S VISIT _____
THIS CONDITION/PROBLEM HAS EXISTED FOR ____ DAYS ____ WEEKS ____ MONTHS ____YEARS
PREVIOUS TREATMENT FOR THIS PROBLEM_____
HAVE YOU EVER BEEN TO A PODIATRIST? ☐ YES ☐ NO WHEN_____ REASON _____
FAMILY PHYSICIAN _____ LAST VISIT _____
ADDRESS _____ PHONE # _____
PHARMACY_____ADDRESS_____PHONE#_____
ARE YOU PRESENTLY BEING TREATED FOR ANY MEDICAL PROBLEMS? (PLEASE DESCRIBE) _____
_____
MEDICATIONS (TAKING PRESENTLY)_____
_____
_____

PLEASE CHECK IF YOU HAVE BEEN TREATED FOR ANY OF THE FOLLOWING:

___ DIABETIC:(last BS_____HbA1c____)	___ GOUT	____ GI. ULCERS	___ POLIO
___ HEART PROBLEMS	____ ARTHRITIS	____ ASTHMA	___STROKE
___ HIGH BLOOD PRESSURE	____ RHEUMATIC FEVER	____ LOW BACK PAIN	___ OTHER
___ SEIZURES	____ ANEMIA	____ CANCER (TYPE: _____)	
___ PHLEBITIS	____ KIDNEY PROBLEMS	____ BLEEDING PROBLEMS	
___ POOR CIRCULATION	___ HEPATITIS	____ HIV/AIDS	

ALLERGIES (PLEASE CHECK IF APPLY):

___ LOCAL ANESTHESIA	___ CODEINE	___ASPIRIN
___ PENICILLIN	___ CORTISONE	____SEAFOOD
___ SULFA DRUGS	___ IODINE/BETADINE	OTHERS_____
___ OTHER ANTIBIOTICS	___ ADHESIVE TAPE	_____

LIST ANY OPERATIONS OR INJURIES: _____
_____

Is there a Family Medical History of: Diabetes YES/NO Heart Disease YES/NO Cancer YES/NO (type:_____)

DO YOU SMOKE? YES / NO___ How many/day? _____ How many years? _____

ARE YOU A FORMER SMOKER? YES / NO Are you exposed to second hand smoke? YES / NO

DO YOU USE SMOKELESS TOBACCO? YES / NO

DO YOU DRINK ALCOHOL? YES / NO___Frequency _____

DO YOU CONSUME CAFFEINE? YES / NO___Frequency _____ _____
Initial

****

NEW GOVERNMENT REQUIRED INFORMATION:

HEIGHT _____ WEIGHT_____

Race: Asian Black Hispanic White Other-_____ If Hispanic- do you consider yourself Latino? YES / NO__

Primary language spoken:_____

****

INSURANCE INFORMATION

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: _____
ADDRESS_____
RELATIONSHIP_____ PHONE _____

PRIMARY MEDICAL INSURANCE_____
NAME OF POLICY HOLDER_____THEIR DATE OF BIRTH_____
RELATIONSHIP_____SS#_____
POLICY #_____ GROUP #_____
IS THIS INSURANCE THROUGH EMPLOYER? YES ☐ NO ☐

SECONDARY MEDICAL INSURANCE _____
NAME OF POLICY HOLDER_____THEIR DATE OF BIRTH_____
RELATIONSHIP_____SS#_____
POLICY #_____ GROUP #_____
IS THIS INSURANCE THROUGH EMPLOYER? YES☐ NO ☐

LIST ANY OTHER MEDICAL INSURANCE COVERAGE: _____
_____

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE ON MY BEHALF TO BLACKWOOD-CLEMENTON FOOT AND ANKLE SPECIALISTS / DRS. KLEIN FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN / SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

I UNDERSTAND THAT THE ULTIMATE RESPONSIBILITY FOR PAYMENT OF SERVICES IS BY THE INSURED (CLAIMS ARE FILED AS A COURTESY). THIS INCLUDES PAYMENT OF ANY LATE FEES THAT ACCRUE (AT A RATE OF $5 PER MONTH) ON OVERDUE ACCOUNTS AS WELL AS REASONABLE ATTORNEY OR COLLECTION FEES IF COLLECTION PROCEEDINGS NEED TO BE INITIATED.

_____
PATIENT'S / GUARDIAN'S SIGNATURE

****

I HEREBY GIVE PERMISSION TO THE DOCTORS TO EXAMINE AND TREAT MY PODIATRIC NEEDS AS DEEMED NECESSARY OR ADVISABLE.

PATIENT'S/GUARDIAN'S SIGNATURE_____DATE_____