



LYNNE J. HAUBELT, D.P.M.
SCOTT G. SOLBACH, D.P.M.
DAVID MANCE, D.P.M.

DATE _____

NAME _____ AGE _____ BIRTHDATE ____ / ____ / ____

ADDRESS _____ CITY _____ ZIPCODE _____

PHONE(____) _____ CELL PHONE(____) _____ WORK(____) _____

EMERGENCY CONTACT _____ PHONE(____) _____

PATIENTS OCCUPATION _____

EMPLOYER _____

INSURANCE _____ ID# _____ GROUP# _____

POLICY HOLDER'S NAME _____ BIRTHDATE ____ / ____ / ____

POLICY HOLDER'S EMPLOYER _____

FAMILY DOCTOR _____ PHONE(____) _____

ARE YOU UNDER THE CARE OF A PHYSICIAN? YES _____ NO _____

IF YES, WHAT FOR _____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS? YES _____ NO _____

IF YES, PLEASE LIST? _____

ANY ALLERGIES? _____

MEDICAL HISTORY

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> HIGHBLOOD PRESSURE | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> KIDNEY DISEASE |
| <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> EYE/EAR TROUBLE |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> PHLEBITIS | <input type="checkbox"/> HORMONE THERAPY | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> CORTISONE TREATMENT |
| <input type="checkbox"/> HIV | <input type="checkbox"/> VENEREAL DISEASE | <input type="checkbox"/> CIRCULATION PROBLEMS | |

ARE YOU OR COULD YOU BE PREGNANT YES _____ NO _____

LAST HOSPITALIZATION & REASON _____

PATIENTS FOOT COMPLAINT _____

HOW DID YOU HEAR ABOUT US? _____

I AUTHORIZE DR. HAUBELT, DR. SOLBACH, DR. MANCE TO PERFORM TESTS AND SUGGEST A TREATMENT PLAN BASED UPON HIS/HER EXAMINATION.

SIGNED _____