associates in podiatry
LYNNE J. HAUBELT, D.P.M.
SCOTT G. SOLBACH, D.P.M.
DAVID MANCE, D.P.M.
SHANNON L. MCFEATERS, D.P.M.

DATE_____

NAME_____AGE____BIRTHDATE____/____/_____

ADDRESS_____CITY_____ZIPCODE_____

PHONE(___)_____WORK(___)_____CELL PHONE(___)_____

EMERGENCY CONTACT_____PHONE(___)_____SPOUSE_____

INSURANCE _____POLICY HOLDER_____ HOLDER DOB___/___/_____

PATIENT'S OCCUPATION_____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 MEDICATION ALLERGIES?_____LATEX ALLERGY__

PHARMACY_____ LOCATION_____

MEDICAL HISTORY

__HEART TROUBLE	__HIGH BLOOD PRESSURE	___TUBERCULOSIS	___KIDNEY DISEASE
__PACEMAKER	___ASTHMA	___ARTHRITIS	___BLEEDING DISORDER
__EYE/EAR TROUBLE	__HEPATITIS	___ANEMIA	___RHEUMATIC FEVER
__PHLEBITIS	___HORMONE THERAPY	___LIVER DISEASE	__CORTISONE TREATMENT
__HIV	___VENEREAL DISEASE	__CIRCULATION PROBLEMS	__DIABETIC ___insulin Y N

ARE THERE ANY OTHER HEALTH CONCERNS/DISORDERS THE DOCTOR SHOULD BE AWARE OF?

NO____YES_____PLEASE LIST_____

DO YOU SMOKE? YES_____ NO_____ ARE YOU OR COULD YOU BE PREGNANT? YES_____NO_____

LAST HOSPITALIZATION & REASON_____

PATIENT'S FOOT COMPLAINT_____

HOW DID YOU HEAR ABOUT US?_____

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

SIGNED_____