

**BLOOMFIELD FOOT SPECIALISTS, LLC 1 NORTHWESTERN DRIVE, SUITE 301
BLOOMFIELD, CT 06002**

Date _____ Email _____

Name _____ Male/Female Marital Status: M D W S

Date of Birth _____ Age _____ Social Security Number _____ - _____ - _____

Preferred Language _____ Race _____ Ethnicity _____ Decline All

Home Address _____

City _____ State _____ Zip _____

Phone: (H) _____ (W) _____ (Cell) _____

Occupation _____ Employer _____

Employer Address _____

Emergency Contact _____ Phone _____
Address _____ Relation _____

Insurance Information:

Primary Insurance _____ I.D. No. _____

Policy Holder _____ Relationship _____

Employer _____ Prescription Insurance Company _____

Secondary Insurance _____ I.D. No. _____

Policy Holder _____ Relationship _____

Employer _____ Prescription Insurance Company _____

Your Pharmacy Name _____ City/Street _____

Family Physician _____ Address _____

Is your visit related to an accident? Yes No Date _____

Is your visit work-related? Yes No

Who referred you to our office? _____

What problem(s) bring you here? _____

Height _____ Weight _____ Shoe Size _____

Medication Allergies: YES NO _____

Metal Allergies: YES NO _____

Other Allergies: YES NO _____

Are you taking Medications? YES NO List: _____

Do You Smoke? _____ How much? _____

Do you drink Alcohol? _____ How much? _____ Social Drinker _____

Family History:

Any immediate relative have a history of:

Arthritis _____ Cancer _____ Diabetes _____ Heart Disease _____

List Any Surgeries:

Date	Operation	Hospital

Have you had any of the following? Please circle Yes or No

Fatigue	Y N	Gastric Reflux	Y N
Dizziness	Y N	Gastric Ulcers	Y N
Recent weight loss	Y N	Hepatitis	Y N
Glaucoma	Y N	Kidney Disease	Y N
Cataracts	Y N	Liver Disease	Y N
Ringin in Ears	Y N	Skin Conditions: _____	
Hearing aids	Y N	Diabetes	Y N
Heart Palpitations	Y N	Thyroid Hypo Hyper	N
High Blood Pressure	Y N	HIV/AIDS	Y N
Heart Murmur	Y N	Anemia	Y N
Pacemaker	Y N	Swelling in Ankles	Y N
Mitral Valve Prolapse	Y N	Bleeding Tendency	Y N
Stroke	Y N	Scarring Tendency	Y N
Chest Pain	Y N	Arthritis: _____	Y N
Shortness of Breath	Y N	Osteoporosis	Y N
Sleep Apnea	Y N	Osteopenia	Y N
Snoring	Y N	Low Back Pain	Y N
Asthma	Y N	Gout	Y N
Pneumonia	Y N	High Cholesterol	Y N
Tuberculosis	Y N	Other Illnesses: _____	

I hereby give permission to have my feet examined by any employee or Doctor of Bloomfield Foot Specialists, LLC. I request that payment of authorized medical or other insurance benefits be paid on my behalf to Bloomfield Foot Specialists, LLC.

I authorize Bloomfield Foot Specialists, LLC, to release any information to my insurance company needed to determine benefits payable for related services.

I do understand and agree that I am ultimately responsible for the balance on my account.

SIGNED _____ DATE _____