BLOOMFIELD FOOT SPECIALISTS, LLC 705 BLOOMFIELD SUITE 201
BLOOMFIELD, CT 06002

Date_____ **Email**_____

Name_____ **Date of Birth**_____

Age_____ Male/Female/Non-binary/Transgender _____M**arital Status**: M D W S

Preferred Language _____ **Social Security Number**_____-_____-_____

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 _____

<u>Are you taking Medications?</u> 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**
Ringing 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_____

PRINT NAME_____ RELATIONSHIP IF NOT PATIENT_____