NEW PATIENTS WELCOME!! NAME ___________________________

A SHORT PERSONAL MEDICAL HISTORY: HAVE YOU EVER HAD…
PLEASE CIRCLE YES OR NO

BLEEDING DISORDER	YES	NO	BONE, JOINT DISEASE	YES	NO
KIDNEY DISEASE	YES	NO	HIATAL HERNIA	YES	NO
STROKE	YES	NO	RHEUMATIC FEVER	YES	NO
ARTHRITIS	YES	NO	POLIO	YES	NO
EPLIEPSY	YES	NO	TUBERCULOSIS	YES	NO
RECTAL DISEASE	YES	NO	HIGH BLOOD PRESSURE	YES	NO
POISONING	YES	NO	SKIN DISEASE	YES	NO
LUNG DISEASE	YES	NO	LIVER DISEASE	YES	NO
STOMACH ULCER	YES	NO	HEART DISEASE	YES	NO
BURSITIS, SCIATICA	YES	NO	ANEMIA	YES	NO
BLADDER DISEASE	YES	NO	CANCER	YES	NO
BOWEL DISEASE	YES	NO	ASTHMA	YES	NO
NERVOUS DISEASE	YES	NO	AIDS-HIV	YES	NO
DIABETES	YES	NO	POOR CIRCULATION	YES	NO
HEPATITIS	YES	NO	BACK PROBLEMS	YES	NO
FAINTING SPELLS	YES	NO	FOOT or LEG CRAMPS	YES	NO
NEUROPATHY	YES	NO	PSYCHIATRIC ISSUES	YES	NO

OTHER MEDICAL PROBLEMS NOT LISTED____

YOUR HEIGHT____________**YOUR WEIGHT (approximate)**________________________

ARE YOU ALLERGIC TO THE FOLLOWING: **PLEASE CIRCLE YES OR NO**
PENICILLAN YES / NO, SULFA YES / NO, ERYTHROMYCIN YES / NO OTHER ANTIBIOTICS YES / NO, ASPRIN YES / NO, CODEINE YES / NO, MORPHINE YES / NO,
LIST FOOD ALLERGIES____

HAVE YOU EVER HAD? PLEASE CIRCLE YES / NO
BROKEN BONES YES / NO HEAD OR NECK INJURY YES / NO, NERVE INJURY YES / NO, SEVERE SPRAINS YES / NO, SURGERIES PLEASE LIST_____________________________
GENERAL ANESTHESIA YES / NO, BLOOD TRANSFUSIONS YES / NO

DO YOU DRINK ANY ALCOHOL? DAILY____WEEKLY____RARELY____NEVER________
DO YOU OR DID YOU EVER SMOKE? YES / NO IF SO, HOW MANY PER DAY ____________
IF STOPPED, WHEN____________; DATE OF LAST TETANUS SHOT _______

CURRENT MEDICATIONS (INLCUDE VITAMINS) ___________________________________
____

PLEASE EXPLAIN YOUR FOOT PROBLEM IN DETAIL_________________________________
____

PATIENT INFORMATION:

NAME OF YOUR MEDICAL DOCTOR, DATE OF LAST VISIT______________________

FULL NAME____________________________DATE OF BIRTH_____________AGE____

ADDRESS____

CITY& ZIP CODE_________________________EMAIL___________________________
HOME PHONE______________________WORK PHONE __________________________
SOCIAL SECURITY NUMBER____

EMPLOYER_________________________________OCCUPATION__________________

SPOUSE/GUARDIAN____
SPOUSE / GUARDIAN DATE OF BIRTH_____________SS#_________________________
SPOUSE / GUARDIAN EMPLOYER____

NAME OF INSURANCE COMPANY____

IS MEDICAL INSURANCE LISTED UNDER" SELF/ SPOUSE, GUARDIAN (PLEASE INDICATE)

INSURANCE ID#_____________, GROUP #____________CO-PAY AMOUNT $________

PATIENT'S MEDICARE AUTHORIZATION:
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Mark E Davison, DPM for any service furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Admin and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agree to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsibly only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

I understand that it must be MEDICALLY NECESSARY in order that Medicare pays for services, cosmetic care is not covered by Medicare.
Signature____

MEDICARE or MEDICARE ADVANTAGE PATIENTS ONLY

HgA1c (%)________________Date of last HgA1c ________________

Have you had a flu shot (and date)______________________________

Your Creatinine/Microalbumin value (ug/mg) _____________________

Do you have Nephropathy (Kidney disease)?______________________

Are you taking ACEI or ARB (blood pressure pills)_________________

When was your last EYE exam _________________________________

Did your EYE exam include a retinal Picture?______________________

Your Height ____

Your Weight (within 5 lbs)_____________________________________

Your current shoe size ____