The Foot & Ankle Clinic

G. D. BINNS & ASSOCIATES

CONFIDENTIAL

Dear Patient,

The information we ask for below is confidential and is to help us to carry out your treatment in the best possible way. If you are not sure about the answer to any question(s) please tell the Receptionist.

General Information

Mr./Mrs./Miss./Ms./Dr. Surname: _____

First & Middle Name(s) or init.: _____

Date of Birth (write as 21 Feb 1965): _____

Mailing Address: _____

Parish: _____ **Postal Code:** _____

Email Address: _____

Phone Number(s): (W) _____ **(H)** _____ **(C)** _____

Insurance Information

Name of Insured (If not Patient)**:** _____

Patient's Relationship to Insured: _____

Insured's Place of Employment: _____

Insurance Company: _____

Policy/Certificate Number: _____

Group Number: _____

Health Information

Name of Doctor (G.P.): _____

When did you last visit a Chiropodist or Podiatrist? _____

Health Information (cont'd)

Do you have or have you ever had:

			Further Details
Heart trouble	**yes**	**no**	_____
Abnormal blood pressure	**yes**	**no**	_____
Rheumatic fever	**yes**	**no**	_____
Jaundice	**yes**	**no**	_____
Diabetes	**yes**	**no**	_____
Leg cramps when walking	**yes**	**no**	_____
Abnormal reaction to penicillin	**yes**	**no**	_____
Allergic to any drug or substance	**yes**	**no**	_____
If applicable, are you pregnant?	**yes**	**no**	_____

Do you take any medication or supplement of any sort regularly for any reason, i.e. steroids, insulin, anti-coagulants (blood thinners), birth control pills, anti-depressants?

yes no

If yes, what are you taking? _____

_____

Have you been treated by a doctor for any serious reason in the last 12 months?

yes no

If yes, please explain. _____

_____

What brings you to the Foot & Ankle Clinic? _____

_____

Is there anything else you think the Podiatrist should know? yes no

If yes, please explain. _____

_____

I, the undersigned, hereby authorize payment of insurance benefits to the attending podiatrist (where applicable), for services rendered to the above named patient, together with the release of any information to process the claim. I understand that I am responsible for the payment in the event that my insurance does not pay.

Signature: _____ **Date:** _____