

**DR. JANE WALTER, D.P.M., P.A.  
PODIATRIST**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

LOCAL ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

P.O. BOX \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE NO. (HOME) \_\_\_\_\_ (OFFICE) \_\_\_\_\_ (CELL) \_\_\_\_\_

HOW DID YOU HEAR ABOUT THIS OFFICE? \_\_\_\_\_

AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

MARITAL STATUS: MARRIED \_\_\_\_\_ SINGLE \_\_\_\_\_ WIDOW \_\_\_\_\_ DIVORCED \_\_\_\_\_

**MEDICAL INSURANCE**

PRIMARY INSURANCE \_\_\_\_\_ NUMBER \_\_\_\_\_

NAME OF CARDHOLDER (IF OTHER THAN SELF) \_\_\_\_\_ DOB \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_ NUMBER \_\_\_\_\_

NAME OF CARDHOLDER (IF OTHER THAN SELF) \_\_\_\_\_ DOB \_\_\_\_\_

ARE YOU A MEMBER OF AN HMO OR PPO? \_\_\_\_\_

**MEDICAL INFORMATION**

WHAT PROBLEM BRINGS YOU TO THIS OFFICE? \_\_\_\_\_

IS THIS THE RESULT OF AN ACCIDENT? PLEASE DESCRIBE BRIEFLY \_\_\_\_\_

HAVE YOU HAD ANY TREATMENT FOR THIS PROBLEM? \_\_\_\_\_

NAME OF FAMILY PHYSICIAN \_\_\_\_\_

NAME OF DIABETIC PHYSICIAN (IF APPLICABLE) \_\_\_\_\_

**MEDICAL INSURANCE AUTHORIZATION SIGNATURE ON FILE**

I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE CARRIERS AND RELEASE OF INFORMATION TO INSURANCE COMPANY. I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL IF INSURANCE DOES NOT PAY.

SIGNATURE \_\_\_\_\_

**PLEASE FILL OUT BOTH SIDES**

A \$10.00 SERVICE CHARGE WILL BE ADDED TO EACH MONTH TO ALL BILLS 60 DAYS AND OVER.

<b>MEDICAL HISTORY</b>	<b>PRESENT</b>	<b>PAST</b>	<b>NEVER</b>
ANEMIA			
ARTHRITIS			
BACK PROBLEMS			
BLADDER PROBLEMS			
CANCER			
CHEST PAIN			
CIRCULATION PROBLEMS			
DIABETES			
EPILEPSY			
EYE PROBLEMS—CATARACTS, GLAUCOMA			
GOUT			
HEART ATTACK			
HIGH BLOOD PRESSURE			
LIVER TROUBLE			
LUNG—EMPHYSEMA, BRONCHITIS			
ASTHMA, OTHER			
RHEUMATIC FEVER			
NEUROLOGIC DISEASE OR STROKE			
SKIN PROBLEMS			
STOMACH PROBLEMS			
TUBERCULOSIS			
OTHER			

LIST MEDICINES, PILLS OR HOME REMEDIES THAT YOU TAKE:

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

LIST OPERATIONS:

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

LIST ALLERGIES:

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |