

# ALAN N. BERMAN, DPM

BOARD CERTIFIED, AMERICAN BOARD OF PODIATRIC SURGERY

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NAME: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
ADDRESS \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

HOME TELEPHONE ( ) \_\_\_\_\_ WORK ( ) \_\_\_\_\_  
E-MAIL ADDRESS \_\_\_\_\_ CELL ( ) \_\_\_\_\_

BIRTHDAY \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
SHOE SIZE \_\_\_\_\_ MARITAL STATUS: Single \_\_\_\_\_ Married \_\_\_\_\_ Other \_\_\_\_\_

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

INSURED'S EMPLOYER NAME \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

IN CASE OF EMERGENCY NOTIFY \_\_\_\_\_  
TELEPHONE ( ) \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

What is your chief foot complaint? \_\_\_\_\_  
Have you ever seen a Podiatrist? \_\_\_\_\_ Last visit \_\_\_\_\_

Whom shall we thank for referring you to our office? \_\_\_\_\_

.....  
I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby authorize payment directly to Dr. Alan Berman of the surgical and/or medical benefits as otherwise payable to me for the services as described.

I understand that any deductible and/or co-insurance is my responsibility.

Patient \_\_\_\_\_ Date \_\_\_\_\_

Insured if different than patient \_\_\_\_\_

SEE NEXT PAGE.....

\*\*\*\*\*PLEASE PRESENT INSURANCE ID CARD TO RECEPTIONIST\*\*\*\*\*

Primary Insurance \_\_\_\_\_ ID # \_\_\_\_\_  
Policy Holders Name \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ ID # \_\_\_\_\_  
Policy Holders Name \_\_\_\_\_

MEDICAL INFORMATION

Primary Physician Name \_\_\_\_\_ Last Visit \_\_\_\_\_

Have you been hospitalized in the last 2 years? Yes \_\_\_\_ No \_\_\_\_

Please list any surgeries you have had:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

Please list any prescription medication you are presently taking:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

Are you allergic to any of the following medications?

Penicillin \_\_\_\_ Codeine \_\_\_\_ Aspirin \_\_\_\_ Novocain \_\_\_\_ Tape \_\_\_\_

Shell Fish \_\_\_\_ Food or other Drugs \_\_\_\_\_

Do you NOW HAVE or have you had in THE PAST any of the following conditions or symptoms?

Arthritis \_\_\_\_

Asthma \_\_\_\_

Cancer \_\_\_\_

Where \_\_\_\_\_

Diabetes \_\_\_\_

Epilepsy \_\_\_\_

Heart Trouble \_\_\_\_

What type \_\_\_\_\_

High Blood Pressure \_\_\_\_

HIV/AIDS \_\_\_\_

Kidney Trouble \_\_\_\_

What type \_\_\_\_\_

Liver Trouble \_\_\_\_

What type \_\_\_\_\_

Leg Cramps \_\_\_\_

When \_\_\_\_\_

Rheumatic Fever \_\_\_\_

Smoker \_\_\_\_

How much \_\_\_\_\_

Substance Abuser \_\_\_\_

ie: Drugs/Alcohol

Ulcers \_\_\_\_

What type \_\_\_\_\_

Other \_\_\_\_\_