DOVE PODIATRY, P.A.

Joseph E. Dove, D.P.M.

Welcome to our office. Below are questions to help us become better acquainted. If you need any help completing this form, please do not hesitate to ask our staff.

*__Patient Full Name__(as it appears on insurance cards):

First_____ Middle_____ Last _____

Single ____ Married ____ Separated ____ Divorced ____ Widowed ____

Home Address:_____

City: _____ Zip code:_____

Home Phone:_____ Cell Phone:_____

Email Address: _____

Social Security Number: _____Date of Birth:_____

Employed by: _____ Occupation: _____

Spouse's Name or Parent: _____ Phone: _____

Nearest Relative/Friend not living with you:_____Phone:_____

Emergency Contact: _____ Phone:_____

Primary Care Physician: _____

Phone: _____Date of last visit by your PCP:_____

Pharmacy: _____Phone: _____

Referred by: _____

I. Primary Insurance: _____
ID# _____ Group# _____
II. Secondary Insurance: _____
ID# _____ Group# _____
III. Tertiary Insurance:_____
ID# _____ Group# _____

Have you ever served in the military? Yes No

1. Does your occupation keep you on your feet?
__sometime __part of the time __most of the time __all of the time

2. Did you sustain an injury at work? Yes No

3. Are your injuries accident related? Yes No

4. Are you covered under an employer or union policy? Yes No

5. What is your shoe size? _____ Height_____ Weight_____

6. What is your current health status?
Excellent _____ Good _____ Fair _____

Surgeries: _____Date_____

_____Date _____

_____Date_____

_____Date_____
Complications/if any: _____

7. Are you subject to prolonged bleeding? Yes No

8. Are you allergic to any of the following?
____ Novocain ____Penicillin ____Adhesive Tape ____Other_____

9. Is there any personal or family history of any of the following?

Diabetes ____Yes ____ No Hepatitis ____Yes __No
Arthritis ____Yes ____No Liver Abnormalities ____Yes __No

10. Do you have low back pain? ____Yes ____ No

11. Do you smoke now? ____Yes ____ #Packs/Day ____# Years ____No

12. If you have quit smoking, when did you do so? _____

13. Do you drink alcoholic beverages? None Rarely Moderately Daily

14. Do you consume recreational drugs? None Rarely Moderately Daily

15. Please list medications and dosages you are currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

16. Do you have or have you ever been treated for any of the following? Please circle:

Stroke	Vascular Disease	Headaches	Phlebitis
Diabetes	Glaucoma	Rheumatic Fever	Alzheimer's
Epilepsy	Tuberculosis	Hepatitis	Gout
Poor Circulation	Asthma	Arthritis	Sciatica
Liver Disease	Osteoporosis	Heart Attack	Lung Disease
Thyroid	Kidney Disease	High Cholesterol	Cancer
Stomach Ulcer	Lyme's Disease	High Blood Pressure	
Nerve Disorder	Psychiatric Disorder	Keloid /Thick Scar	
Heart Condition	Hearing/Ear Disorder		

17. Flu Shot Yes_____ No_____ Date_____

18. Pneumonia Shot Yes _____ No _____ Date_____

19. Last AIC (**For Diabetics Only**) _____

20. What is the reason for your visit today?

_____

***Co-Pays and Referrals are due upon visit. If a referral is required by your insurance, it is the patient's responsibility to request one from your primary care physician prior to your scheduled appointment. If you have any questions regarding your insurance coverage, please contact the member service number on the back of your insurance card. Patient's arriving without a referral or co-pay will be rescheduled to another date.**

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AUTHORIZATION TO BILL YOUR INSURANCE COMPANY

Medicare Policy Holders

I request that payment of authorized Medicare benefits be made directly to **Joseph E. Dove, D.P.M.** for any services furnished to me by him. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits.

I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under title XVII of the Social Security Act.

Commercial Insurances

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to **Joseph E. Dove, D.P.M.**

I understand and agree that, regardless of my insurance status, I am ultimately financially responsible for the balance of my account for any professional services rendered. I have read all the information above and completed the information to the best of my knowledge. I certify that this information is true and correct. I will notify you of any changes in my status or the above information as soon as they occur.

A copy of this signature is as valid as the original.

Signature: _____ Date: _____