REASON FOR VISIT

Please list your present health concerns, problems or symptoms: ____________________

____

MEDICAL HISTORY

When was your last physical exam? ____________________

Physician's Name ____________________ Phone ____________________

Your drugstore / pharmacy : ____________________ Phone ____________________

1. Are you currently under medical treatment?....................( )Yes ( )No
   Please describe: ____________________
2. Have you ever had any serious illnesses or operations?....................( )Yes ( )No
   Please describe: ____________________
   ____
3. Are you currently taking any medication?....................( )Yes ( ) No
   Please describe: ____________________
   ____
4. Do you smoke?....................( )Yes ( )No
5. Do you use alcohol, cocaine, or other drugs?....................( )Yes ( )No

6. Have you had any allergic reactions to the following:

	YES	NO
Local Anesthetucs (eg. Novacaine).........	( )	( )
Penicillin or other Anitbiotics..................	( )	( )
Sulfa Drugs..	( )	( )
Barbiturates (sleeping pills).................	( )	( )
Sedatives..	( )	( )
Iodine...	( )	( )
Aspirin..	( )	( )
Other..	( )	( )

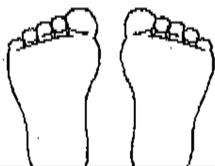
Have you ever had the following:

	Yes	No		Yes	No		Yes	No
Anemia....................			Hernia....................			Psychiatric Care....................		
Anorexia....................			Herpes....................			Respiratory Disease....................		
Arthritis....................			High Blood Pressure....................			Rheumatic Fever....................		
Asthma....................			HIV / AIDS....................			Scarlet Fever....................		
Back Problems....................			Jaundice....................			Shortness of Breath....................		
Bleeding Tendency....................			Kidney Disease....................			Sinus Trouble....................		
Cancer....................			Liver Disease....................			Skin Rash....................		
Chemical Dependency....................			Low Blood Pressure....................			Stroke....................		
Chemotherapy....................			Measles....................			Thyroid Problems....................		
Chicken Pox....................			Migraine Headaches....................			Tonsillitis....................		
Circulatory Problems....................			Mitral Valve Prolapse....................			Tuberculosis....................		
Congenital Heart Lesions....................			Mumps....................			Ulcer....................		
Diabetes....................			Multiple Sclerosis....................			Venereal Disease....................		
Epilepsy....................			Pacemaker....................			Any Other Condition....................		
Glaucoma....................			Phlebitis....................			Please describe:		
Heart Murmur....................			Pneumonia....................					
Heart Disease....................			Polio....................					
Hepatitis-Type....................			Prostate Problem....................					

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to The Foot & Ankle Centre of New Jersey for all insurance benefits otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all service rendered on my behalf or my dependents.
I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits.
I authorize the use of this signature on all insurance submissions.

Signature of Responsible ____________________ Date ____________



DAVID P. LUONGO, DPM

Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

PATIENT INFORMATION

Date ____________ Soc. Sec. # ____________ Birthdate ____________

Name ____
Last Name First Name Initial

Address ____________ Home Phone ____________

City ____________ State ____________ Zip ____________

Sex: ( ) M ( ) F ( )Minor ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

Employer ____________ Business Phone ____________

Business Address ____________ Occupation ____________

Whom may we thank for referring you? ____________

In case of emergency, whom should we contact? ____________ Phone ____________

PRIMARY INSURANCE

Person Responsible for Account ____
Last Name First Name Initial

Relationship to Patient ____________ Birthdate ____________ Soc. Sec. # ____________

Address ____________ Home Phone ____________

City ____________ State ____________ Zip ____________

Responsible Party Employed By ____________ Business Phone ____________

Business Address ____________ Occupation ____________

Insurance Company ____________

Insurance Company Address ____________

Subscriber I. D. # ____________ Group # ____________

ADDITIONAL INSURANCE

Insured Name ____
Last Name First Name Initial

Relationship to Patient ____________ Birthdate ____________ Soc. Sec. # ____________

Address ____________ Home Phone ____________

City ____________ State ____________ Zip ____________

Insured Employed By ____________ Business Phone ____________

Insurance Company ____________

Insurance Company Address ____________

Subscriber I.D. # ____________ Group # ____________

PLEASE COMPLETE REVERSE SIDE