Welcome to Brookfield Podiatry

Please fill out this form COMPLETELY
Write N/A where applicable and sign it.
Thank You

First Name:	M.I.:	Last Name:
By what name do you prefer to be called:		
Date of Birth: / /	Pharmacy:	
Primary Insurance:		Insured Cardholder: Date of Birth:
Gender: *Male Female*	Marital Status: *Single Married Widowed Divorced*	
EMAIL ADDRESS for appointment reminder:		
Street Address:		City:
State:	Zip:	Employer Name:
Home Phone:		Occupation:
Work Phone:		Emergency Contact:
Cell Phone:		Emergency Phone:
Who referred you to our office?		Primary Care Physician:
Reason for today's visit:		

RIGHT FOOT ☐ LEFT FOOT ☐ BOTH ☐

Medical History

	YES	NO		YES	NO
Diabetes	☐	☐	Poor Circulation	☐	☐
Arthritis	☐	☐	Asthma	☐	☐
Heart Problems	☐	☐	High or Low Blood Pressure	☐	☐
Thyroid Problems	☐	☐	Liver Disease	☐	☐

Other Medical Conditions not listed:_____

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT IT IS AS A COURTESY THE DOCTOR ACCEPT MY INSURANCE FOR PAYMENT AND THAT IF FOR ANY REASON THEY DO NOT PAY MY BILL THAT I AM RESPONSIBLE.

Today's Date_____ Patient's Signature_____