	<u>**PATII</u>	ENT INFORMATI	<u>ON**</u>		
DATE:					
NAME:					
LAST ADDRESS:				MIDDLE	
NUMBER STREET		APT. CIT		STATE	ZIP
EMAIL:					
MARITAL STATUS:					
EMPLOYER NAME/ADDRESS:					
PRIMARY CARE DOCTOR: Name, Address & P					
PREFERRED PHARMACY:					
	hone Number is <b>Requirec</b>				
PRIMARY LANGUAGE:	ETHNICITY:	HISPANIC OF	LATINO	NOT HISPANIO	C OR LATINO
RACE: AMERICAN INDIAN OR ALASKAN NATIV		WAIIAN OR OTHER PAC AFRICAN AMERICAN	FIC ISLANDER	WHITE	
How did you hear about us: Primary Insurance					p or other
	**FINANCIAL	LY RESPONSIBLE	E PERSON**		
NAME: REL	ATION TO PATIENT:	РНО	NE:		
ADDRESS:		EMA	IL:		
EMPLOYER NAME/ADDRESS:					
OTHER PERSON TO NOTIFY IN EMERGENCY:		PHONE#			_
	**MEDICAI	INSURANCE CO	VERAGE**		
NAME OF PRIMARY INS. CO			VENAGE		
ID/POLICY#		GROUP#:			
POLICY HOLDER NAME:		D.O.B.: GUARDIAN			
RELATIONSHIP TO HOLDERSELF	3PO03E	_GOARDIAN			
NAME OF SECONDARY INS. CO.					
ID/POLICY#		GROUP#:			
POLICY HOLDER NAME:		D.O.B.:			
RELATIONSHIP TO HOLDER:SEL	SPOUSE	GUARDIAN			
I understand and acknowled	ge that I am p	personally res	ponsible fo	or the serv	vices rendered at this
facility. Lakeforest Foot and	Ankle Center	will bill my	insurance	as a cour	tesy. In the event o

SIGNATURE OF SUBSCRIBER OR BENEFICIARY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Practices and that I have read (or had the opportunity or read if I so chose) and understood the Notice.

non-payment, I understand I will be responsible for any outstanding balances.

DATE

### LAKEFOREST FOOT AND ANKLE CENTER DRS. TABOR AND WEBER, PA

#### **FINANCIAL POLICY**

#### NEW INSURANCE

Please notify us immediately if your insurance has changed.

#### <u>COPAYMENT</u>

Please know that all copayments are due at the time of your appointment.

#### COMPLETION OF FORMS

All forms to be completed by medical staff members will be subject to a **\$15 charge** that will be paid at the time the form is submitted.

#### **NO SHOW/ CANCELATION FEE**

If you miss your scheduled appointment without notifying our office within 24 hours or reschedule the same day, a **\$25 charge** will be added to your account.

#### RETURNING CHECK FEE

\$50.00 charge for all returned checks

### ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent) have insurance coverage with

\_\_\_\_\_\_ and assign directly to Drs. Tabor and Weber, PA all insurance benefits, payable to me for services rendered. I understand that I am responsible for all information necessary to secure payment of benefits. I authorize **RELEASE OF MEDICAL INFORMATION** to my insurance carrier, any third party as it materially relates to services provided or requested by physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

By my signature I acknowledge receipt of a copy of this policy and hereby agree to its terms.

Signature:
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Printed Name:	Date:	/	/
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What is the reason for your visit today?         When did your symptoms start?         What medical problems do you have or are you being treated for? Please circle all that Apply:         Alcoholism       Depression         Margies/Hayfever       Diabetes Type 1         Kidney infections         Allergies/Hayfever       Diabetes Type 2         Milgraine         Anxiety       Epliepsy         Antial Eibrillation       Gastro Ulcer         Old MM/ Heart Attack         Blood Transfusions       Gastro Ulcer         Cardia Pacer       Osteoprosis         Cardia Pacer       Glaucoma         Cardia Pacer       Glaucoma         Cardia Pacer       Glaucoma         Corlisis       High Cholesterol         Rheumatic Fever       Terminal Illness         Corlisis       High Cholesterol         Rheumatic Fever       Terminal Illness         Corlisis       High Cholesterol         Rheumatic Fever       Corlision         Corlisis       High Cholesterol         Resction:       Emperthyroidism         Corlisis       High Cholesterol         Corlisis thypertiplidemia       Sexually Transmitted Disease         Corhis Disease       Hypothyroidism	Name:	Height:	Weight:	Shoe Size:
What medical problems do you have or are you being treated for? Please circle all that Apply:       Alcoholism       Kidney infections         Allergies/Hayfever       Diabetes Type 1       Kidney Stone       Anemia         Anemia       Diabetes Type 2       Migraine         Anxiety       Epilepsy       Multiple Sclerois/MS         Astima       Fracture       Obesity         Arial Fibrillation       Gastric Ulcer       Old MI/ Heart Tatck         Blood Transfusions       Gastrointestinal Disease       Osteoarthritis         CAD/Heart Disease       GEND/Acid Refux       Osteoporosis         Cardiac Pacer       Giaucoma       Progressive Neurological Disorder         Cardiavascular Disease       Heart Murmur       Pulmonary Disease/Lung Problem         Heart Failure/CHF       Hepatitis       Rheumatic Prever         Cirrhosis       High Cholesterol       Rheumatic Prever         Cirhosis       Hyperthyroidism       Thyroid Disease         CAP/Kidney Failure       Hyperthyroidism       Thyroid Disease         CAP/Kidney Failure       Hyperthyroidism       Thyroid Disease         CVA/Stroke       Lisulin Pump       Tuberculosis/TB         DVT/Clot       Joint Pain       Valvular Problems         Other Medical History:       Preselist	What is the reason for your visit	today?		
Alcoholism Depression Kidney infections Allergies/Hayfever Diabetes Type 1 Kidney infections Allergies/Hayfever Diabetes Type 2 Miltiple Sciences/MS Anemia Diabetes Type 2 Miltiple Sciences/MS Astma Fracture Obesity Atrial Fibrillation Gastric Ulcer Old MI/ Heart Attack Blood Transfusions Gastrointestinal Disease Osteoarthritis CAD/Heart Disease GERD/Acid Reflux Osteoporosis Cancer Gestational Diabetes Pneumonia Cardia Pacer Gastational Diabetes Pneumonia Cardia Pacer Gastational Diabetes Preumonia Cardia Pacer Glaucoma Progressive Neurological Disorder Cardiovascular Disease Heart Murmur Pulunonary Disease/Ling Problem Conforsis High Cholesterol Rheumatic Arthritis COItis Hyperfliptemia Secually Transmitted Disease/STD COPD Hyperthyroldism Thyroid Disease Crohn's Disease Hypothyroldism TiA/Mini-Stroke CA/Kidney Fallure Hyperthyroldism TiA/Mini-Stroke CA/Kidney Fallure Hyperthyroldism TiA/Mini-Stroke CA/Kidney Fallure Please list any operations you have ever had:	When did your symptoms start?			
Allergies/Hayfever       Diabetes Type 1       Kidney Store         Anemia       Diabetes Type 2       Migraine         Anxiety       Epliepsy       Multiple Sciencis/MS         Astima       Fracture       Obesity         Arrial Fibrillation       Gastric Ulcer       Old M// Heart Attack         Blood Transfusions       Gastrointestinal Disease       Osteoporosis         CAD/Heart Disease       GEND/Acid Reflux       Osteoporosis         Cancer       Gestational Diabetes       Pneumonia         Cardia Pacer       Glaucoma       Progressive Neurological Disorde         Cardia Pacer       Hepatitis       Rheumatic Fever         Cirthosis       High Cholesterol       Rheumatic Fever         Corbis Disease       Hypertipidemia       Secually Transmitted Disease/STD         COPD       Hyperthyroidism       TIA/Mini-Stroke         CV/X5troke       Insulin Pump       Tuberculosis/TB         DVT/Clot       Jo	What medical problems do you h	have or are you being treated for?	Please circle all that	: Apply:
Anemia     Diabetes Type 2     Migraine       Anxiety     Epilepsy     Multiple Sclerosis/MS       Axity     Epilepsy     Multiple Sclerosis/MS       Artial Fibrillation     Gastric Ulcer     Old M/I Heart Attack       Blood Transfusions     Gastric Ulcer     Old M/I Heart Attack       Blood Transfusions     Gastric Ulcer     Old M/I Heart Attack       Cancer     Gestational Disease     Osteoprorsis       Cardiac Pacer     Gestational Diabetes     Pneumonia       Cardiac Scare     Gestational Diabetes     Pneumonia       Cardiacy Scare     Gestational Diabetes     Pneumonia       Cardiacy Scare     Heart Murmur     Pulmonary Disease/Lung Problem       Cardiacy Scare     Heart Murmur     Pulmonary Disease/Lung Problem       Cardiacy Scare     Hyperthypidemia     Sexually Transmitted Disease/STD       COPD     Hyperthypidism     Thyproid Disease       CAF/Kidney Failure     Hyperthyroidism     Th/Mini-Stoke       CAF/Kidney Failure     Hyperthyroidism     Th/Mini-Stoke <t< td=""><td>Alcoholism</td><td>Depression</td><td></td><td>Kidney infections</td></t<>	Alcoholism	Depression		Kidney infections
Anxiety Epilepsy Multiple Sclerosis/MS Asthma Fracture Obesity Athral Fibrillation Gastric Ulcer Old MI/ Heart Attack Blood Transfusions Gastro Ilcer Old MI/ Heart Attack CAD/Heart Disease GERD/Acid Reflux Osteoporosis Cancer Gestational Diabetes Pneumonia Cardiac Pacer Glaucoma Progressive Neurological Disorder Cardiovascular Disease Heart Murmur Pulmonary Disease/Lung Problem Heart Failure/CHF Hepatitis Rheumatic Fever Cirrhosis High Cholesterol Rheumatic Fever Cirrhosis High Cholesterol Rheumatic Disease STD COPD Hypertipidemia Sexually Transmitted Disease/STD COPD Hypertension/High Blood Pressure Terminal Illness CTA/Stroke Insulin Pump Tuberculosis/TB DVT/Clot Joint Pain Valvular Problems DVT/Clot Joint Pain Please list any operations you have ever had:	Allergies/Hayfever	Diabetes Type 1		Kidney Stone
Asthmä     Fracture     Obesity       Artial Fibrillation     Gastric Ulcer     Old MI/ Heart Attack       Blood Transfusions     Gastrointestinal Disease     Osteoarthritis       CAD/Heart Disease     GERD/Acid Reflux     Osteoarthritis       Cancer     Gestational Diabetes     Pneumonia       Cardiac Pacer     Glaucoma     Progressive Neurological Disorder       Cardiovascular Disease     Heart Murmur     Pulmonary Disease/Lung Problem       Heart Fallure/CHF     Hepatitis     Rheumatic Fever       Cirrhosis     High Cholesterol     Rheumatic Fever       Cirrhosis     Hyperthipidemia     Sexually Transmitted Disease/STC       COPD     Hyperthyroidism     Thyroid Disease       Crohn's Disease     Hypothyroidism     Ti/A/Mini-Stroke       CVA/Stroke     Insulin Pump     Tuberculosis/TB       DVT/Clot     Joint Pain     Valvular Problems       Other Medical History:	Anemia	Diabetes Type 2		Migraine
Atrial Fibrillation     Gastric Ulcer     Old MI/ Heart Attack       Blood Transfusions     Gastrointestinal Disease     Osteoaptritis       Blood Transfusions     Gastrointestinal Disease     Osteoaptritis       Cardiae Pacer     Galacoma     Progressive Neurological Disorder       Cardioacular Disease     Heart Murruur     Pullmonary Disease/Lung Problem       Heart Failure/CHF     Hepatitis     Rheumatic Fever       Cirrhosis     High Cholesterol     Rheumatic Atritis       COPD     Hyperlpidemia     Sexually Transmitted Disease/STC       COPD     Hypertonsion/High Blood Pressure     Terminal Illness       CArkiney Failure     Hyperthyroidism     TitA/Mini-Stroke       CVA/Stroke     Insulin Pump     Tuberculosis/TB       DVT/Clot     Joint Pain     Valvular Problems       Other Medical History:	Anxiety	Epilepsy		Multiple Sclerosis/MS
Blood Transfusions Gastrointestinal Disease Osteoarthritis CAD/Heart Disease GERD/Acid Reflux Osteoporosis CAD/Heart Disease GERD/Acid Reflux Osteoporosis Cancer Gaucoma Progressive Neurological Disorder Cardiovascular Disease Heart Nurmur Pulmonary Disease/Lung Problem Heart Failure/CHF Hepatitis Rheumatic Fever Cirrhosis High Cholesterol Rheumatoid Arthritis COPD Hypertension/High Blood Pressure Terminal Illness CRF/Kidney Failure Hypertlipidemia Sexually Transmitted Disease/STD CV/Stroke Insulin Pump Tuberculosis/TB DVT/Clot Joint Pain Valvular Problems Please list any allergies to medications: Name: Reaction: React	Asthma	Fracture		Obesity
CAD/Heart Disease GERD/Acid Reflux Osteoporosis Cancer Gestational Diabetes Pneumonia Cardiac Pacer Gestational Diabetes Progressive Neurological Disorder Cardiovascular Disease Heart Murmur Pulmonary Disease/Lung Problem Heart Failure/CHF Hepatitis Rheumatic Fever Cirrhosis High Cholesterol Rheumatic Fever Cirrhosis High Cholesterol Rheumatic Fever COPD Hypertension/High Blood Pressure Terminal Illness CAD/Keart Paine Hyperthyroidism Thyroid Disease CAV/Stroke Insulin Pump Tuberculosis/TB DVT/Clot Joint Pain Valvular Problems DVT/Clot Congenital Anomaly Hypertension/High Blood Pressure Please list any allergies to medications: Name: Reaction: Reaction: Name: Corden Congenital Anomaly Hypertension/High Blood Pressure Anemia COPD Hyperison Liver Disease Statima Depression Liver Disease Kidney Disease Statima Depression Liver Disease Statima Depression Liver Disease Statima Depression Liver Disease Cardiovascular Disease GERD/Acid Reflux Osteoporosis Cardiovascular Disease GERD/Acid Reflux Osteoporosis Cardiovascular Disease GERD/Acid Reflux Osteoporosis Cardiovascular Disease Carde Reflux Corden Stroke Cardiovascular Disease Carde Reflux Osteoporosis Cardiovascular Disease GERD/Acid Reflux Osteoporosis Cardiovascular Disease Carde Reflux Osteoporosis Cardiovascular Disease Carde Reflux Osteoporosis Cardiovascular Disease GERD/Acid Reflux Osteoporosis Cardiovascular Disease Carde Reflux Osteoporosis Cardiovascular Disease Carde Reflux Osteoporosis Cardiovascular Disease Cardiovascular Disease Cardiovascular Disease Cardiovascular Disease Cardiovascular Disease Cardiovascular Disease Carde Reflux Osteoporosis Cardiovascular Disease Carder Hypertipidemia Stroke Smoking Status: Current every day smoker Cardiovascular Disease Carders Never Smoker Cardiovascular Disease Carder Carder Stroke Strok	Atrial Fibrillation	Gastric Ulcer		Old MI/ Heart Attack
Cancer Gestational Diabetes Pneumonia Cardia Pacer Glaucoma Progressive Neurological Disorder Cardiovascular Disease Heart Murmur Pulmonary Disease/Lung Problem Heart Failure/CHF Hepatitis Rheumatic Fever Cirrhosis High Cholesterol Rheumatic Arthritis Collitis Hyperlipidemia Sexually Transmitted Disease/STC COPD Hyperthyroidism Thyroid Disease CRF/Kidney Failure Hyperthyroidism Thyroid Disease CRF/Kidney Failure Hyperthyroidism Thyroid Disease CVA/Stroke Insulin Pump Tuberculosis/TB DVT/Clot Joint Pain Valvular Problems Other Medical History:  Please list all medications you are currently taking including Strength:  Please list all medications you are currently taking including Strength:  Please list any allergies to medications: Name:  Reaction:  Please Circle) Alcoholism Congenital Anomaly Hypertension/High Blood Pressure Antenia COPD Hypertsion Liver Disease Strhma Depression Liver Disease Strhma Depression Liver Disease Epilepsy Osteoarthritis Cardiovascular Disease GERD/Acid Reflux Osteoporosis Cardiovascular Disease GERD/Acid Reflux Osteoporosis Cardiovascular Disease GERD/Acid Reflux Current some day smoker  Current every day smoker Current some day smoker Never smoker	Blood Transfusions	Gastrointestinal Disea	se	Osteoarthritis
Cancer Gestational Diabetes Pneumonia Cardia Pacer Glaucoma Progressive Neurological Disorder Cardiovascular Disease Heart Murrnur Pulmonary Disease/Lung Problem Heart Failure/CHF Hepatitis Rheumatic Fever Cirrhosis High Cholesterol Rheumatid Arthritis Colltis Hyperlipidemia Sexually Transmitted Disease/STC COPD Hyperthyroidism Thryroid Disease CRF/Kidney Failure Hyperthyroidism Thryroid Disease Crochn's Disease Hypothyroidism Thryroid Disease CVA/Stroke Insulin Pump Tuberculosis/TB DVT/Clot Joint Pain Valvular Problems DVT/Clot Joint Pain Valvular Problems Please list any operations you have ever had: Please list any allergies to medications: Name: Reaction: Please list any allergies to medications: Name: Reaction: Name: Reaction: Name: COPD Hypertson Reaction: Name: COPD Hypertson Reaction: Name: COPD Hypertson Reaction: Name: Reaction: Reaction: Name: Reaction: Reaction: Name: Reaction: Reaction: Name: Reaction: Reaction: Reaction: Name: Reaction: Rea	CAD/Heart Disease	GERD/Acid Reflux		Osteoporosis
Cardiovascular Disease Heart Murmur Pulmonary Disease/Lung Problem Pear Failure/CHF Hepatitis Rheumatic Fever Crithosis High Cholesterol Rheumatic Fever Crithosis High Cholesterol Rheumatic fever Comminal Illness Chry Kidney Failure Hypertinyiodism Thyroid Disease Crohr's Disease Hypothyroidism Th/Wini-Stroke CrA/Stroke Insulin Pump Tuberculosis/TB DVT/Clot Joint Pain Valvular Problems Other Medical History:	Cancer	Gestational Diabetes		-
Cardiovascular Disease Heart Murmur Pulmonary Disease/Lung Problem Heart Failure/CHF Hepatitis Rheumatic Fever Cirrhosis High Cholesterol Rheumatoid Arthritis Colitis Hyperlipidemia Sexually Transmitted Disease/STD COPD Hypertension/High Blood Pressure Terminal Illness CRF/Kidney Failure Hyperthyroidism Thyroid Disease Crohr's Disease Hypothyroidism TIA/Mini-Stroke CVA/Stroke Insulin Pump Tuberculosis/TB DVT/Clot Joint Pain Valvular Problems DVT/Clot Strange Status:	Cardiac Pacer	Glaucoma		Progressive Neurological Disorder
Heart Failure/CHF       Hepatitis       Rheumatic Fever         Cirrhosis       High Cholesterol       Rheumatic Fever         Cirrhosis       Hyperlipidemia       Sexually Transmitted Disease/STC         COPD       Hypertension/High Blood Pressure       Terminal illness         CRF/Kidney Failure       Hyperthyroidism       Th/Yroid Disease         Crohn's Disease       Hypothyroidism       Th/Mini-Stroke         CVA/Stroke       Insulin Pump       Tuberculosis/TB         DVT/Clot       Joint Pain       Valvular Problems         Other Medical History:	Cardiovascular Disease	Heart Murmur		Pulmonary Disease/Lung Problem
Cirrhosis High Cholesterol Rheumatoid Arthritis Coltis Hyperlipidemia Sexually Transmitted Disease/STC COPD Hypertension/High Blood Pressure Terminal Illness CRF/Kidney Failure Hyperthyroidism TIA/Vinii-Stroke Crohn's Disease Hypothyroidism TIA/Mini-Stroke Please list any operations you have ever had: Please list all medications you are currently taking including Strength: Please list any allergies to medications: Name:	Heart Failure/CHF	Hepatitis		
Colitis Hyperlipidemia Sexually Transmitted Disease/STD COPD Hypertension/High Blood Pressure Terminal Illness CRF/Kidney Failure Hyperthyroidism Thyroid Disease CRF/Kidney Failure Hyperthyroidism Thyroid Disease Crohn's Disease Hypothyroidism Th/Vinin-Stroke CVA/Stroke Insulin Pump Tuberculosis/TB DVT/Clot Joint Pain Valvular Problems Other Medical History:		-		
COPD       Hypertension/High Blood Pressure       Terminal Illness         CRF/Kidney Failure       Hyperthyroidism       Thyroid Disease         Crohn's Disease       Hypothyroidism       TIA/Mini-Stroke         CVA/Stroke       Insulin Pump       Tuberculosis/TB         DVT/Clot       Joint Pain       Valvular Problems         Other Medical History:		_		
CRF/Kidney Failure Hyperthyroidism Thyroid Disease Crohn's Disease Hypothyroidism TIA/Mini-Stroke CVA/Stroke Insulin Pump Tuberculosis/TB DVT/Clot Joint Pain Valvular Problems Dther Medical History: Please list any operations you have ever had: Please list all medications you are currently taking including Strength: Please list all medications you are currently taking including Strength: Please list any allergies to medications: Name: Reaction: Name: Reaction: Reaction: Reaction: Reaction: Anemia COPD Hypothyroidism Anxiety Crohn's Disease Kidney Disease Birth Defects Diabetes Multiple Births CAD/Heart Disease GERD/Acid Reflux Osteoporosis CAD/Heart Failure Hypercholesterolemia Stroke Smoking Status:Current every day smokerCurrent some day smoker			ood Pressure	-
Crohn's Disease Hypothyroidism TIA/Mini-Stroke Insulin Pump Tuberculosis/TB DVT/Clot Joint Pain Valvular Problems Other Medical History:				
CVA/Stroke       Insulin Pump       Tuberculosis/TB         DVT/Clot       Joint Pain       Valvular Problems         Dther Medical History:				-
DVT/Clot       Joint Pain       Valvular Problems         Other Medical History:				
Other Medical History:		•		-
Please list any operations you have ever had:	•			valvulai riobieniis
Name:	Please list all medications you a	re currently taking including Strei	ngth:	
Name:				
Name:	Please list any allergies to medic	cations:		
Name:       Reaction:         Family History (Please Circle)       Hypertension/High Blood Pressure         Alcoholism       Congenital Anomaly       Hypertension/High Blood Pressure         Anemia       COPD       Hypothyroidism         Anxiety       Crohn's Disease       Kidney Disease         Asthma       Depression       Liver Disease         Birth Defects       Diabetes       Multiple Births         CAD/Heart Disease       Epilepsy       Osteoarthritis         Cardiovascular Disease       GERD/Acid Reflux       Osteoporosis         CHF/Heart Failure       Hyperlipidemia       Stroke         Smoking Status:       Current every day smoker       Current some day smoker         Former smoker       Never smoker	Name:		Reaction:	
Family History (Please Circle)AlcoholismCongenital AnomalyHypertension/High Blood PressureAnemiaCOPDHypothyroidismAnxietyCrohn's DiseaseKidney DiseaseAsthmaDepressionLiver DiseaseBirth DefectsDiabetesMultiple BirthsCAD/Heart DiseaseEpilepsyOsteoporosisCardiovascular DiseaseGERD/Acid RefluxOsteoporosisCHF/Heart FailureHypercholesterolemiaPulmonary DiseaseCancer:Lurrent every day smokerCurrent some day smokerFormer smokerNever smoker	Name:			
AlcoholismCongenital AnomalyHypertension/High Blood PressureAnemiaCOPDHypothyroidismAnxietyCrohn's DiseaseKidney DiseaseAsthmaDepressionLiver DiseaseBirth DefectsDiabetesMultiple BirthsCAD/Heart DiseaseEpilepsyOsteoarthritisCardiovascular DiseaseGERD/Acid RefluxOsteoporosisCHF/Heart FailureHypercholesterolemiaPulmonary DiseaseCancer:Kurrent every day smoker Former smokerCurrent some day smoker			Reaction:	
AnemiaCOPDHypothyroidismAnxietyCrohn's DiseaseKidney DiseaseAsthmaDepressionLiver DiseaseBirth DefectsDiabetesMultiple BirthsCAD/Heart DiseaseEpilepsyOsteoarthritisCardiovascular DiseaseGERD/Acid RefluxOsteoporosisCHF/Heart FailureHypercholesterolemiaPulmonary DiseaseCancer:				
AnxietyCrohn's DiseaseKidney DiseaseAsthmaDepressionLiver DiseaseBirth DefectsDiabetesMultiple BirthsCAD/Heart DiseaseEpilepsyOsteoarthritisCardiovascular DiseaseGERD/Acid RefluxOsteoporosisCHF/Heart FailureHypercholesterolemiaPulmonary DiseaseCancer:HyperlipidemiaStrokeSmoking Status:Current every day smokerCurrent some day smokerFormer smokerNever smoker	Alcoholism	Congenital Anomaly		_
AsthmaDepressionLiver DiseaseBirth DefectsDiabetesMultiple BirthsCAD/Heart DiseaseEpilepsyOsteoarthritisCardiovascular DiseaseGERD/Acid RefluxOsteoporosisCHF/Heart FailureHypercholesterolemiaPulmonary DiseaseCancer:HyperlipidemiaStrokeSmoking Status:Current every day smokerCurrent some day smokerFormer smokerNever smoker	Anemia	COPD	Hypot	hvroidism
Birth DefectsDiabetesMultiple BirthsCAD/Heart DiseaseEpilepsyOsteoarthritisCardiovascular DiseaseGERD/Acid RefluxOsteoporosisCHF/Heart FailureHypercholesterolemiaPulmonary DiseaseCancer:HyperlipidemiaStrokeSmoking Status:Current every day smokerCurrent some day smokerFormer smokerNever smoker				-
CAD/Heart DiseaseEpilepsyOsteoarthritisCardiovascular DiseaseGERD/Acid RefluxOsteoporosisCHF/Heart FailureHypercholesterolemiaPulmonary DiseaseCancer:HyperlipidemiaStrokeSmoking Status:Current every day smokerCurrent some day smokerFormer smokerNever smoker		Crohn's Disease		-
Cardiovascular Disease       GERD/Acid Reflux       Osteoporosis         CHF/Heart Failure       Hypercholesterolemia       Pulmonary Disease         Cancer:       Hyperlipidemia       Stroke         Smoking Status:       Current every day smoker       Current some day smoker         Former smoker       Never smoker	Anxiety		Kidne	Disease
CHF/Heart Failure       Hypercholesterolemia       Pulmonary Disease         Cancer:       Hyperlipidemia       Stroke         Smoking Status:       Current every day smoker       Current some day smoker         Former smoker       Never smoker	Anxiety Asthma	Depression	Kidne Liver I	y Disease Disease
Cancer: Hyperlipidemia Stroke Smoking Status: Current every day smoker Current some day smoker Former smoker Never smoker	Anxiety Asthma Birth Defects	Depression Diabetes	Kidne Liver I Multij	y Disease Disease Die Births
Smoking Status:       Current every day smoker         Former smoker       Never smoker	Anxiety Asthma Birth Defects CAD/Heart Disease	Depression Diabetes Epilepsy	Kidne Liver I Multip Osteo	y Disease Disease ble Births arthritis
Former smoker Never smoker	Anxiety Asthma Birth Defects CAD/Heart Disease Cardiovascular Disease	Depression Diabetes Epilepsy GERD/Acid Reflux	Kidne Liver I Multij Osteo Osteo	y Disease Disease ole Births arthritis porosis
	Anxiety Asthma Birth Defects CAD/Heart Disease Cardiovascular Disease CHF/Heart Failure	Depression Diabetes Epilepsy GERD/Acid Reflux Hypercholesterolemia	Kidne Liver I Multij Osteo Osteo Pulmo	y Disease Disease Die Births arthritis porosis Diary Disease
Tobacco Use:YESNO	Anxiety Asthma Birth Defects CAD/Heart Disease Cardiovascular Disease CHF/Heart Failure Cancer: Smoking Status: Current ev	Depression Diabetes Epilepsy GERD/Acid Reflux Hypercholesterolemia Hyperlipidemia very day smoker Currer	Kidne Liver I Multij Osteo Osteo Pulmo Stroke	y Disease Disease Die Births arthritis porosis Diagra Disease
	Anxiety Asthma Birth Defects CAD/Heart Disease Cardiovascular Disease CHF/Heart Failure Cancer: Smoking Status: Current ev	Depression Diabetes Epilepsy GERD/Acid Reflux Hypercholesterolemia Hyperlipidemia very day smoker Currer	Kidne Liver I Multij Osteo Osteo Pulmo Stroke	y Disease Disease Die Births arthritis porosis Diary Disease

# Do you frequently experience, or have you recently experienced any of the following symptoms? Please Circle:

Weight change (gain or loss) Fever Chills Feeling tired or poorly Weakness

Rapid or irregular heartbeat (palpitations) Chest pain

Cough Wheezing Difficulty breathing Shortness of breath

Poor appetite Light-colored bowel movement Nausea Vomiting Diarrhea Abdominal pain Abnormal liver function tests

Arthritis	- Gout
Back pain	- Muscle aches
Joint pain	- Muscle cramps
Seizures Weakness Numbness	<ul><li>Tingling sensation</li><li>Burning sensation</li></ul>
Rash	- Bruising
Itching	- Hives
Dry skin	- Flushing
Cysts or other masses under skin	- Skin bump (small or large)

I certify that the above information is true and correct to the best of my knowledge. I give permission to Drs. Tabor, Weber and Nagorski to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature	~f	nationt	~ ~	lagal	guardian
Signature	OL	Datient	or	iegai	guardian
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- Cold hands and feet

- Calf pain while walking

# **Medical Information Release Form**

Name:	Date of birth:	/	/
			′ <b>——</b> ——

## **Release of Information**

[] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to (**please provide first and last name**):

[] Spouse			
-			

[ ] Child(ren)\_\_\_\_\_\_

[] Information is not to be released to **anyone**.

The *release* of this information will remain in effect until terminated by me in writing

Signed:	Date:	/	/
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