Practice: Warren Altwerger DPM

Today's Date:

Name: ____________________ **DOB:** __________ **Chart Number:** __________

Sex: ☐M ☐F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#:** __________

E-mail: ____________________ **Spouse/Partner Name:** __________

E-mail newsletters, reminders, statements, etc. **Emergency Name:** __________ **Phone:** __________

Address: ____________________ **City:** __________ **State:** ______ **Zip:** __________

Home #: __________ **Cell #:** __________ **Other #:** __________

Employer: ____________________ **Phone:** __________

Employer Address: ____________________ **City:** __________ **State:** ______ **Zip:** __________

Primary Insurance: ____________________ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: __________ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ other

Phone #: __________ Sex: ☐Male ☐Female DOB: ___/___/___

Address: ____________________

Policy ID: __________ Group ID: __________ Employer: __________

Secondary Insurance: ____________________ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: __________ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ Other

Phone #: __________ Sex: ☐Male ☐Female DOB: ___/___/___

Address: ____________________

Policy ID: __________ Group ID: __________ Employer: __________

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend ☐ Other: __________

What is the reason for your visit today? ____________________

____________________ **Result of accident or work injury?** ☐Yes ☐No

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? ____________________

____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling Other:__________

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: ____________________ Date: __________