

SOUND FOOT CARE, PC

Ronald A. Washington, D.P.M

2 Brookside Drive

Smithtown, NY 11787

www.soundfootcare.net

Welcome to **SOUND FOOT CARE**. For our records, please complete the following information:

Today's Date: _____

PERSONAL INFORMATION:

Patient's Name: _____

Date of Birth: _____ Marital Status: S M W D other _____

Address: _____

Telephone number: Home: _____ Work: _____ Cell: _____

Social Security Number: _____ e-mail address: _____

Responsible Party: _____

EMPLOYMENT/FULL TIME STUDENT: (Please circle) Yes No

Address: _____

Occupation: _____

School/University: _____

INSURANCE INFORMATION:

Primary Insurance: _____

Address: _____

Telephone number: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber's Social Security Number (if different): _____

Insured's Name: _____

Policy Number: _____ Group Number: _____

Whom can we thank for referring you to our office? _____

Because of ever rising administrative costs, **payments** and **co-payments** are required at the time of your appointment. Please be advised that insurance companies are responsible to only you, the insured, not the doctor. Although we will make every effort to facilitate your insurance billing, you, the patient, are responsible for the total charge incurred. If Dr. Washington is a provider of your insurance, your co-payment is due in full at each visit. Please make sure ALL information is updated. You are responsible for ALL deductibles and co-payments. A 24-hour notice must be made if you cannot keep your appointment. If no notice is made, **you** will be responsible for the charge of an office visit: **\$ 75.00**. This is our Office Policy. **READ YOUR HEALTH INSURANCE POLICY, THOROUGHLY.**

By signing this form, I have completed it to the best of my knowledge and that I have read and understood the above office policy.

Signature of Patient/Responsible Party: _____

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Welcome to **SOUND FOOT CARE**. For our records, please complete the following Medical information:

Today's Date: _____

PERSONAL PHYSICIAN: _____ Last Seen: _____

PREVIOUS PODIATRIST: _____ Last Seen: _____

Are you in generally good health? Yes _____ No _____

Are you taking ANY medications? Yes _____ No _____

If yes, please list ALL medications:

Medication and dosage

Medications and Dosage

• _____	• _____
• _____	• _____
• _____	• _____
• _____	• _____
• _____	• _____
• _____	• _____

Please continue on back, if needed.

Have you had ANY serious illnesses in the past? Yes _____ No _____

Please list ALL illnesses:

Have you been hospitalized in the past 12 months? Yes _____ No _____

If yes, please describe reason for hospitalization:

I AM ALLERGIC TO, OR HAVE A REACTION TO:

Adhesive Tape _____	Codeine _____	Novocaine _____	Penicillin _____
Sulfur _____	Aspirin _____	Acetaminophen _____	Ibuprofen _____
Other _____	Other _____	Other _____	Other _____
_____	_____	_____	_____
_____	_____	_____	_____

Date of last Tetanus Shot _____

I HAVE HAD OR CURRENTLY HAVE:

Arthritis _____	Hepatitis _____	Heart Condition _____	Kidney disorders _____
Anemia _____	High Blood _____	Circulatory _____	Nervousness _____
Diabetes _____	Pressure _____	problems _____	Rheumatic fever _____
Hemophilia _____	HIV/AIDS _____	Liver ailments _____	Tuberculosis _____
Varicose veins _____	Joint disease _____	Thyroid _____	Other _____
Cancer _____	Other _____	_____	_____
_____	_____	_____	_____

Please continue on back, if needed, to list medical condition not listed above.

Has anyone from your immediate family been treated for any of the above health problems? Yes _____ No _____

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Patient's Name (continued): _____

Are you pregnant? Yes _____ **No** _____

What is your chief foot complaint?

Signature: _____ **Date:** _____

If patient is a minor, please have legal guardian sign and date.