Patient Information

PERSONAL INFORMATION **Current Date: _____**

First Name**:** _____ Middle**:** _____ Last**:** _____

Date of Birth**:**_____ Age**:** _____ Sex: _____M_____ F Social Sec. Number: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Next of Kin/Spouse: _____

Email: _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

INSURANCE INFO: Policy Holders Name**:** _____

Policy Number**:** _____ Group Number**:**_____

Language**:** _____ Race**:** _____ Ethnicity**:** _____

Employer**:** _____ Work Phone**:** _____

INITIAL VISIT: Reason for your visit: _____

_____Date of onset: _____

Name of Primary Care Physician: _____ Date of last visit: _____

The name of your primary care doctor and date of last visit MUST be completed by all Medicare/diabetic patients*

CURRENT MEDICATIONS / DOSAGES

_____ _____

_____ _____

_____ _____

ALLERGIES **(Circle any that apply)**

Penicillin Sulfa Aspirin Codeine Iodine Tape Latex Gloves

Other**:** _____ No known drug allergies: _____

Past surgical procedures**:** ____

____

Family Medical History: ____

____

General Childhood Diseases: (Circle any that apply)   Measles   Mumps   Chicken Pox

Scarlet Fever   Whooping cough   Other: ___________________________________

Please circle any and all of the following that apply: High Blood Pressure   Diabetes   T.B.   Gout
Cancer   Heart Problems   Asthma   Epilepsy   Rheumatic Fever   Kidney Problems

Anemia   Liver Problems   Arthritis   Abdominal Problems   Bursitis   Blood clots

Circulation Problems   Nerve Problems   Known Bleeding Tendencies   Stroke

Other: ____

How did you hear about our office? Newspaper: _____   Internet: _____   Phone Book: _____

Physician: _____   Friend / Relative: _____   Allied Health: _____

I hereby give my permission to Dr. Conway McLean, DABFAS, FAPWHc to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and / or treatment of my lower extremity condition.

Signature of Responsible Party: ________________________________   ***Date:*** _________________

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OFFICE USE ONLY

WEIGHT ________________   BLOOD PRESSURE________________   PULSE_____________

CONWAY T McLEAN D.P.M.
700 W Washington St, Ste B
Marquette, MI. 49855

"LIFE TIME AUTHORIZATION"

Previously, Physicians had to obtain the patient's signature for each claim, or, Physicians using the "Signature on file" had to have the patient's authorization for each date of services. By signing this form below, we may eliminate the need for your signature every time you visit the office. We thank you for your assistance

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I request payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Conway McLean, D.P.M., for any services furnished to me by him. I authorize any holder of medical information about me to be released to the Health Care financing Administration and its agents, any information needed to determine these benefits or the benefits payable to related services.

_____
Patients or authorized person's signature Date

_____
Please print Patient's full name

I authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to Conway T. McLean, D.P.M. for service described on attached claims. I agree to take responsibility for co-payments, deductibles, and any amounts not covered by my insurance company.

_____
Patients or authorized person's signature Date

_____
Please print Patient's full name

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____
Patients or authorized person's signature Date

_____

Please print Patient's full name