Karen M. Ackerman, D.P.M., P.A.
Welcome to our Office

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SEX: ___ M ___ F AGE: _____ BIRTHDAY: _____ SS#: _____

HOME PHONE #: _____ CELL PHONE #: _____

BEST TIME & PLACE TO REACH YOU: _____ EMAIL: _____

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED

INSURANCE INFORMATION: (WE WILL TAKE A COPY OF YOUR CARD(S))

YOUR EMPLOYER: _____ WORK PHONE #: _____

EMPLOYER ADDRESS: _____

SPOUSES'S NAME: _____ BIRTHDATE: _____ SS#: _____

SPOUSE'S EMPLOYER: _____ WORK PHONE #: _____

EMPLOYER'S ADDRESS: _____

IF PATIENT IS A MINOR: (MUST be filled out)

FATHER'S NAME: _____ SS #: _____ BIRTHDATE: _____

EMPLOYER: _____ WORK PHONE #: _____

MOTHER'S NAME: _____ SS #: _____ BIRTHDATE: _____

EMPLOYER _____ WORK PHONE #: _____

IN CASE OF EMERGENCY, CONTACT:

NAME: _____ RELATIONSHIP: _____

HOME PHONE #: _____ CELL PHONE #: _____

MY FOOT PROBLEM(S) IS/ARE: _____

THIS PROBLEM HAS EXISTED FOR: ____ DAYS ____ WEEKS ____ MONTHS ____ YEARS SHOE SIZE: _____

HAVE YOU EVER BEEN TO SEE A PODIATRIST? ____ YES ____ NO IF YES, NAME: _____

FAMILY PHYSICIAN: _____ LAST VISIT: _____

PHYSICIAN ADDRESS: _____

MEDICATIONS YOU TAKE (INCLUDE OVER THE COUNTER MEDICATION, VITAMINS): _____

_____

MY PHARMACY (AND LOCATION): _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

CONTINUED ON BACK

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IS THERE **ANY FAMILY** HISTORY OF DIABETES? ____ YES ____ NO WHOM? _____

CIGARETTE OR TOBACCO USE? _____ YES ____ NO _____ PREVIOUS

IF YES, HOW LONG? _____ # OF PACKS PER DAY: _____

LIST ALL **SURGERIES** YOU HAVE HAD: _____

_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING: *(CHECK ALL THAT APPLY)*

___ AIDS/HIV	___ CHEMICAL DEPENDENCY	___ HEPATITIS/JAUNDICE	___ RHEUMATIC FEVER
___ ANEMIA	___ CIRCULATORY PROBLEMS	___ HIGH BLOOD PRESSURE	___ SKIN ULCERS
___ ANKLE/FOOT PAIN	___ CORNS/CALLUSES	___ INGROWN NAIL	___ STOMACH ULCERS
___ ARTHRITIS	___ DIABETES **(Type: _____)**	___ KIDNEY PROBLEMS	___ STROKE
___ ARTIFICIAL VALVES/JOINTS	___ EPILEPSY/SEIZURES	___ LIVER DISEASE	___ SWELLING ANKLES/FEET
___ ASTHMA	___ EYE PROBLEMS	___ LOW BLOOD PRESSURE	___ TIRED FEET
___ ATHLETE'S FOOT	___ FLAT FEET	___ NERVOUS PROBLEMS	___ TUBERCULOSIS
___ BACK PROBLEMS	___ FOOT/LEG CRAMPS	___ NUMB FEET	___ UNEQUAL LEG LENGTH
___ BLEEDING DISORDER	___ GOUT	___ PHLEBITIS	___ VARICOSE VEINS
___ BLOOD CLOTS	___ HEADACHES	___ POLIO	___ VENERAL DISEASE
___ BLOOD DISORDERS	___ HEART DISEASE	___ PSYCHIATRIC CARE	___ WARTS ON FEET
___ BUNIONS	___ HEEL PAIN	___ RASH	___ WEIGHT LOSS, UNEXPLAINED
___ CANCER (Type: _____)	___ HEMOPHILIA	___ RESPIRATORY DISEASE	

___ OTHER: _____

ARE YOU ALLERGIC OR SENSITIVE TO: *(CHECK ALL THAT APPLY)*

___ NO KNOWN ALLERGIES

___ ADHESIVE TAPE	___ CODEINE	___ LOCAL ANESTHETICS	___ SEAFOODS
___ ANTICOAGULANT THERAPY	___ DEMEROL	___ NOVOCAINE	___ SULFA
___ ASPIRIN	___ IODINE	___ PENICILLIN	___ OTHER: _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE PERMISSION TO DR. KAREN ACKERMAN, OR A DESIGNATED ASSISTANT OR ASSOCIATE, TO EXAMINE AND TREAT MY FEET AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE SERVICES RENDERED.

_____ _____

PATIENT (PARENT OR GUARDIAN IF A MINOR) SIGNATURE DATE