

PATIENT INFORMATION & HEALTH HISTORY

Patient Name _____ Date of Birth _____
Address _____ Apt# _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Employer _____ Work Phone _____
Social Security # _____ Drivers License # _____
Email address _____
Male _____ Female _____ Minor _____ Single _____ Married _____ Other _____
Spouse or Parent (if minor) _____ Phone _____
Person to contact in case of emergency _____ Phone _____
Whom may we thank for referring you? _____

Person insurance is held under _____
Ins. holder relationship to patient _____ Date of Birth _____
Social Security # _____ Employer _____
Home Phone _____ Cell Phone _____ Work Phone _____
Email address _____
Insurance Company Name _____
I.D. # _____ Group # _____

Medical History

Name of primary doctor _____ Date of last medical exam _____
Have you been hospitalized in the last 5 years? Yes _____ No _____
Reason _____

Do you or have you ever had: (circle each)

Aids Yes No
Anemia Yes No
Arthritis Yes No
Diabetes Yes No
Gout Yes No
Hepatitis Yes No
Hypertension Yes No
Heart Problems Yes No
Heart Murmur Yes No
Abnormal Bleeding Yes No

Are you allergic to? (circle each)

Penicillin Yes No
Anesthetic Yes No
Medication Yes No
Allergy to any other drugs? (list)

Please list any medications you are taking _____

Any other physical conditions we should know about? _____

Adrienne Sabin, D.P.M.
560 E. St. John Street
San Jose, CA 95112
(408) 275-9200

CONSENT FOR TREATMENT

I hereby grant complete authority to Adrienne C. Sabin, D.P.M., to administer any treatment and to administer such X-rays, anesthetics and to perform such podiatric procedures as may be deemed necessary or advisable in the diagnosis and treatment of my podiatric condition.

Please understand your bill is your own personal full responsibility. Insurance is designed to reimburse the policyholder for a loss and is a contract between the policyholder and the company. In the event your company is slow to pay or for some reason disallows the claim, payment of the account is your responsibility. We cannot be responsible for misinformation given to us or unapproved charges at our facility or any lab facility.

Print Patient Name _____

Date _____

Your Signature _____

Relationship to patient: _____
(if patient is a minor or handicapped)