Gregory J. Mowen, DPM

Patient Name: _____ **Sex: M F** **Birthdate:** _____

Street Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip:** _____ **Social Security#:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Marital Status: ( )Single ( )Married ( )Widowed ( )Other Employer: _____

Emergency Contact: _____ **Phone#:** _____ **How did you hear about us:** _____

Ethnicity ( )Hispanic/Latino ( )Non Hispanic/Latino Preferred Language: _____

Race: ( )White ( )African American ( )American Indian ( )Asian ( )Hawaiian/Pacific Islander ( )Other

Primary Care Doctor _____ **Phone #:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Please bring all insurance cards with you to your visit.

Primary Ins: _____ **Policy #:** _____ **Group #:** _____

Subscriber: _____ **DOB:** _____ **Relationship:** _____

Second Ins: _____ **Policy #:** _____ **Group #:** _____

Subscriber: _____ **DOB:** _____ **Relationship:** _____

Authorization to Release Information: I hereby authorize **Gregory J. Mowen, DPM** to release any information required in the course of my examination and treatment.

Initial Here:_____

Authorization to Treat: I hereby authorize **Gregory J. Mowen, DPM** to provide treatment for myself or if a minor, I hereby authorize treatment as a parent or legal representative/guardian.

Initial Here:_____

Authorization to Pay: I hereby authorize payment directly to **Gregory J. Mowen, DPM** for any medical services rendered. I understand that I am fully responsible for any balance not covered by my health insurance.

Initial Here:_____

HMO/PPO Plans: All copays **must** be satisfied each and every visit. There can be no exceptions due to contracting and uniform compliance rules. You are also responsible for getting the proper referral information in advance of your appointment.

_____ _____

Patient Signature Date

_____ _____

Parent/Legal Guardian Signature Date

Patient Medical History

Patient Name: _____ **Birthdate:** _____

Please describe your foot or ankle problem that brought you to the office today: _____

Have you seen a podiatrist before? ( )Yes ( )No If yes, please describe the problem treated: _____

Do you or have you ever had any of the following:

	Yes	No		Yes	No
Diabetes			Hepatitis		
Abnormal bleeding problem			Hypertension (High Blood Pressure)		
Abnormal blood pressure			HIV		
Abnormal heart condition			Kidney Disease		
Arthritis			Liver Disease		
Asthma			Lung Disease		
Cancer			Pacemaker		
Coumadin/Blood Thinners			Seizures or Epilepsy		
Difficulty healing			Stomach Ulcer		
Gout			Stroke		
			Thyroid Disease		

Describe any other medical problems you have that are not mentioned above: _____

Describe any hospitalizations or surgeries: _____

Pharmacy: _____ **Location/City:** _____

List current medications: _____

Allergies:

	Yes	No		Yes	No
Adhesive Tape			Penicillin		
Aspirin			Shellfish		
Codeine			Sulfa		
Novocain			Other?		

Do you have a family history of: ( )Diabetes ( )Blood Clots ( )Bleeding Problems ( )Strokes ( )Gout If yes, which family member(s)? _____
Do you smoke? ( )Yes ( )No If yes number of pack(s) per day? _____
Do you drink alcohol? ( )Yes ( )No If yes, ( )Regularly ( )Socially If yes please describe: _____
Do you exercise? ( )Yes ( )No If yes, how much and how often? _____

_____ _____

Signature **Date**