

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Pharmacy & Phone #: \_\_\_\_\_

Primary Physicians Name/ Phone #: \_\_\_\_\_

**SOCIAL HISTORY**

Married      Single      Divorced      Widowed

Employed: \_\_ Y \_\_ N Occupation: \_\_\_\_\_

Alcohol: \_\_\_\_\_ How Much: \_\_\_\_\_ Tobacco: \_\_\_\_\_ How Much: \_\_\_\_\_

**MEDICAL HISTORY**- Please check all that apply to your medical history.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Accident/ Injuries    | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Cancer            |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Digestive Issues    | <input type="checkbox"/> Ear/ Nose/ Throat |
| <input type="checkbox"/> Epilepsy/ Seizures    | <input type="checkbox"/> Eye (Glaucoma)      | <input type="checkbox"/> Gout              |
| <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Immune Diseases   |
| <input type="checkbox"/> Kidney                | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Lung              |
| <input type="checkbox"/> Neurology             | <input type="checkbox"/> OB/GYN              | <input type="checkbox"/> Orthopedic        |
| <input type="checkbox"/> Psychology            | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Thyroid           |
| <input type="checkbox"/> Vascular/ Circulatory | <input type="checkbox"/> Other               |  |

**FAMILY HISTORY**

\_\_\_\_\_

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**MEDICATIONS**

1) \_\_\_\_\_ 2) \_\_\_\_\_

3) \_\_\_\_\_ 4) \_\_\_\_\_

**ALLERGIES & DRUG REACTIONS**

1) \_\_\_\_\_ 2) \_\_\_\_\_

3) \_\_\_\_\_ 4) \_\_\_\_\_

**EXPLANATION OF PAYMENT POLICY & PRIVACY POLICY**

I hereby authorize Jaryl G. Korpinen DPM to release medical information pertinent to the filing of insurance claims for me. I authorize my insurance carrier to pay benefits directly to Jaryl G. Korpinen DPM on any unpaid services filed on my behalf. I understand that I AM RESPONSIBLE for payment to Jaryl G. Korpinen DPM for charges for the above patient regardless of my insurance coverage. I also understand that Jaryl G. Korpinen DPM is not ultimately responsible for collecting my insurance or negotiating settlements of claims. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have had the opportunity to read and understand the Notice. I also hereby give Jaryl G. Korpinen DPM permission to diagnose and administer treatment for my foot and/or ankle condition and authorize any release of information obtained in the course of my treatment.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_