WILLIAM J. NAMEN II D.P.M, P.A.

NEW PATIENT PACKET

{Please Print}

Today's Date: ___/ ___/ ___

Patient Name: ___________________________________ Date of Birth: ___/___/ ___ Age: ____

Sex: F M Race: _____________ Ethnicity: _____________ Language: ____________

Social security # (Optional) ___________________ Email: _______________________________

Home Address: ____

City/State: _________________________________ Zip: _________________

Home Phone #: (____) ____- ____

Cell Phone#: (____) ___ - ____

Work Phone#: (____) ___- ___

If patient is a minor, please provide the name of parent/guardian: _______________________

Medical Power of Attorney? Yes No

Emergency Contact: ________________Relationship: __________________Phone# _______

Name of Primary Care Doctor: ___________________________ Phone#: _________________

Name of Referring Physician: ____________________________ Phone#: _________________

Name of Management Physician: _________________________ Phone#: _________________

Pharmacy: ____________________________ Location: ___________ Phone#: ______________

Is there a family or member or other person you would like for us to share your medical information?

______ YES Name{s} ____

______ NO

Who is responsible for payment? _______________________ Relationship: ________________

WILLIAM J. NAMEN II D.P.M, P.A.

Insurance Information

Primary Insurance:

Insurance Name: ____

Insurance Claim Address: __________________________________

Policy Number: ______________________________________

Subscriber's Name: __________________ **Subscriber's Social:** ____________________

Subscriber's Date of Birth: _____________ **Relationship to Subscriber's:** _____________

Secondary Insurance {If applicable}

Insurance Name: ____

Insurance Claim Address: __________________________________

Policy Number: ______________________________________

Subscriber's Name: __________________ **Subscriber's Social:** ____________________

Subscriber's Date of Birth: _____________ **Relationship to Subscriber's:** _____________

If this is related to an auto accident, please provide the following information:

Name of Insurance Company: ____

Insurance Claim Address: ____

Claim Number: _________________ **Date of Accident:** ______________________

Adjuster Name: _________________ **Phone #:** _____________________________

WILLIAM J. NAMEN II D.P.M P.A.

Social History

Marital Status M S D W

Use of Alcohol: Never ______ No longer Use _______ History Alcohol Abuse ________

If yes, type of alcohol __________________ Frequency _____________per day

Use of Tobacco: Never ____ Quit -how long ago _______ If yes,

Coffee? Yes ____ No ____ Tea? Yes______ No_____

Use of Smoker: Never _______ No longer use _______

If yes, times per day __________ Packs _______

Weight ___________________ Height _______________________

Employer: _________________________________ Occupation: ________________________

Exercise: Never Rare Occasional Weekly Several times a week Daily

Types of Exercise: ____

Patient Medical History

Allergies of: {select}

Medication ______________________________________

Anesthesia ______________________________________

Foods ____

Tape ____ Latex _____Shellfish ____ Iodine ____ Other ________________

None Know ________

Past History

Cardiovascular____

Neuromuscular____

Orthopedic ____

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Hospitalization____

Surgical Procedures____

Respiratory____

Current Problem

What specific problem brings you to our office today? _______________________________

Where is the pain/problem located? ____

Have you ever had any of the following?

Acid Reflux	Y	N
Anemia	Y	N
Arthritis	Y	N
Asthma	Y	N
Back Trouble	Y	N
Bladder Infections	Y	N
Abnormal Bleeding	Y	N
Blood Clots	Y	N
Blood Transfusion	Y	N
Cancer	Y	N
Diabetes	Y	N
Fibromyalgia	Y	N
Gout	Y	N
Heart Attack	Y	N
Heart Disease	Y	N
Hepatitis	Y	N
HIV/Aids	Y	N
High Blood Pressure	Y	N
Kidney Disease	Y	N
Liver Disease	Y	N
Neuropathy	Y	N
Skin Disorder	Y	N
Stroke	Y	N
Thyroid Disease	Y	N
Tuberculosis	Y	N

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Family History

Mother ____

Father ____

Sibling {s} ____

Please list all medications you are currently taking. Medications include prescription and over-the counter. Bring this list with you to your first appointment.

MEDICATION NAME	HOW MANY TIMES A DAY	MILLIGRAMS	PRESCRIBER

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the Doctor and staff of any changes in my medical status.

Print Name ____ Date _______________________

Signature _______________________________________