Dr. Evan B. Kelner, D.P.M. **PATIENT INFORMATION FORM**

Date of service: _____

Patient name: _____ Date of birth: _____ Gender: Male_____ Female____

Marital status: Single___ Married___ Widow___ Divorced___ Social Security #:_____

Home address: _____ City: _____ Zip: _____

Home phone: _____ Cell: _____ Work: _____

Pharmacy name and address: _____ Primary care physician: _____

Emergency contact: _____ Email address: _____

Primary insurance carrier: _____ ID#_____

Subscriber name: _____ _____ Relationship to patient: Self___ Spouse___ Child___

Secondary insurance carrier: _____ ID#_____

Subscriber name: _____ Relationship to patient: Self___ Spouse___ Child___

How did you hear about our practice? Physician___ Internet___ Phone book___ Family member___ Friend___ Sign___ Other___

If referred by family, friend or Physician please list the name: _____

Reason for today's visit? _____ Have you been treated previously? Yes___ No___

Smoking Status Current medications: _____

Current smoker ____ _____

Former smoker ____ _____

Never smoked ____ Allergies: _____

Decline to answer ____ _____ Height _____ Weight_____

Personal data

Preferred language: _____ Prefer not to answer ____ Ethnicity: _____ Prefer not to answer____

Race: _____ Prefer not to answer____ Religion: _____ Prefer not to answer____

Medical history

Heart disease___ Arthritis___ High blood pressure___ Asthma___ Diabetes___ Kidney disease___ Liver disease___ Gout___

Neuropathy___ Thyroid disease___ Blood clots___ Depression___ Stroke___ Cancer___ Bleeding disorder___ Hammer toe___

Tuberculosis___ HIV___ AIDS___ Swelling___ Epilepsy___ Varicose veins___ Are you pregnant? Yes___ No___

Please list previous surgeries_____

Patient signature: _____ Date: _____