OWINGS MILLS PODIATRY

LION SASSOON, DPM
PETER C. HOFFMAN, DPM

NEW PATIENT INFORMATION SHEET

DATE: _____

PATIENT'S NAME: _____ DOB ___/___/____ M/F

ADDRESS: _____ CITY_____ STATE _____ ZIP _____

HOME PHONE: _____ WORK _____ CELL _____

EMAIL: _____

EMERGENCY CONTACT_____ PHONE NUMBER_____

PRIMARY CARE PHYSICIAN: _____

PHARMACY _____ PHONE NUMBER_____

PRIMARY INSURANCE:	SECONDARY INSURANCE:
POLICY #:	POLICY#:
POLICY HOLDER'S NAME & DATE OF BIRTH:	POLICY HOLDER'S NAME & DATE OF BIRTH:
RELATIONSHIP TO PATIENT:	RELATIONSHIP TO PATIENT:

REFERRED BY OR HOW DID YOU HEAR OF US: _____

WHY DID YOU COME TO THE PODIATRIST? _____

PAYMENTS: Patients are responsible for all fees including missed visits, late cancels and returned checks. Payment is expected at the time the service is rendered. Referrals are the responsibility of the patient to obtain and that charges incurred from the absence of a referral are the responsibility of the patient.
I AUTHORIZE Lion Sassoon DPM LLC and the providers of such company to provide services, and medications, and submit my insurance form, consider my signature "on file" for payment, pictures and to release any and all records needed for insurance processing and communication with other caregivers, including images. I understand the HIPAA, office privacy policy and have read and understand the above and agree to be personally responsible for all charges and fees.

Signature of patient or responsible party: _____

Printed name: _____ Date ____/____/____

9199 REISTERSTOWN ROAD -SUITE 107B - OWINGS MILLS, MD 21117
(P) 410-998-3993 -(F) 410-998-3995

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PATIENT NAME: _____ DOB ___/___/_____

ALLERGIES: PLEASE CIRCLE IF IT APPLIES TO YOU:

Adhesive Tape – Aspirin – Codeine – Demerol – Erythromycin – Latex – Iodine – Local Anesthesia – Morphine –

Penicillin – Sulfa – Other_____

SURGICAL HISTORY: PLEASE CHECK IF YOU HAVE EVER HAD SURGERY IN YOUR LIFETIME:

Foot Surgery _____ By Pass Surgery _____ Cardiac _____ Back _____ GYN _____

Joint Replacement _____ Neurological _____Vascular _____ Other _____

SOCIAL HISTORY (CHECK ONE)

Tobacco – Never _____ Current_____ Former_____
Drug Abuse – Yes _____ No_____
Alcohol Use - Social _____ None _____

PLEASE CHECK IF YOU HAVE ANY OF THE CONDITIONS OR HAVE HAD THEM IN THE PAST:

AIDS		Depression		Kidney Disease	
Alzheimer's		Thyroid		Liver Disease	
Anemia		Gerd/Reflux		Osteoporosis	
Asthma		Athletes Foot		Heart Attack	
Blood clots		Cellulitis		Phlebitis	
Diabetes		Hepatitis		Anxiety	
COPD		High Blood Pressure		Pregnancy (Now)	
Cancer		High Cholesterol		Raynaud's	
Rheum. Arthritis		Seizures		Stomach Ulcer	
Osteoarthritis		Stroke		Other	

REVIEW OF SYSTEMS – CIRCLE IF ANY APPLY TO YOU PAST OR PRESENT:

CONSTITUTIONAL
Weight Gain – Weight Loss

CARDIOVASCULAR
Chest Pain – Heart Palp.
Irregular Heartbeat

EMNT
Ears Ring – Deaf – Sinus
Difficulty Hearing

LYMPHATIC
Ankle Edema (swelling)

MUSCULOSKETAL
Heel Pain / Back Pain
Hip Pain / Leg Cramps

INTEGUMENT
Eczema -Psoriasis – Dry Skin
Itching – Leg Ulcers – Warts
Melanoma – Non-Healing Wounds

RESPIRATORY
Shortness of Breath

EYES
Cataracts-Legally Blind
Blurred Vision

GENIOURINARY
Urinary Frequency
Urgency- Incontinence

NEUROLOGICAL
Numbness - Tingling

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PATIENT NAME: _____ DOB ___/___/_____

HEIGHT _____ **WEIGHT** _____ **A1C** (IF APPLICABLE) _____

FAMILY HISTORY: CHECK THE APPROPRIATE BOX

	MOTHER	FATHER
Gout		
Diabetes		
Osteoporosis		
Osteoarthritis		
Rheumatoid Arthritis		
Poor Circulation/PAD		

MEDICATION LIST - CHECK IF YOU BROUGHT A LIST WITH YOU _____ (WE WILL COPY IT)

Medication	Reason the Medication is Prescribed
1.	
2.	
3.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

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