Print Form

Dr. Daniel Bank, DPM, FACFAS

Welcome to our office. Please complete and sign this form. If completing this form online, please print to bring to your appointment.

Name _____ _____ ____ Male☐ Female☐ E-mail _____
Last First MI

Phone# _____ _____ _____ Best number to reach you?_____
Home Work Cell

Address _____ City_____ State _____ Zip _____

Social Security #_____ Age _____ Date of Birth_____ Married☐ Single☐ Divorced☐ Widow☐

Employer_____ Address _____ City_____ State____ Zip_____

Name of Spouse _____ Spouse Employer _____Spouse phone # _____

Referred by? _____ Primary Care Physician _____

Emergency contact _____ Phone #_____ Relationship _____

Medical Insurance Information

Primary Ins. Co._____ Secondary Ins. Co. _____

Subscriber's Name _____ Sub. Name _____

Subscriber's SS # _____ Sub. SS # _____

Subscriber's date of birth _____ Sub. Date of birth _____

Insurance billing address _____

I declare that the above information is true and correct and that I have read and understand the information written above. I hereby authorize Dr. Daniel Bank to provide medical or emergency care to the above named person or myself. I authorize my insurance company to pay benefits directly to Dr. Daniel Bank and also acknowledge that non-covered services are my responsibility.

Signature_____ Date _____

If patient is a MINOR, please complete this section

Name of Mother_____ Name of Father _____

Address (M)_____ Address (F) _____

SS # (M) _____ SS # (F) _____

Home Phone # (M) _____ Home Phone # (F) _____

Work Phone # (M)_____ Work # (F) _____

Employer (M) _____ Employer (F) _____

If patient is a minor, I hereby authorize Dr. Daniel Bank to treat the above named minor for any medical care.

Signature of patient or guardian_____ Date _____

Notice of Privacy Practices I acknowledge that I have been informed of the Notice of Privacy Practices, and that a copy is available upon request.

Signature_____ Date _____

CURRENT PROBLEM: _____

Where?: _____ How long?: _____

Previous treatment (x-rays, medication, other doctors, etc.) : _____

Dr. Daniel Bank, DPM, FACFAS

NAME: DATE:

MEDICAL HISTORY

ALLERGIES ☐ NONE ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Aspirin ☐ Tape ☐ Latex ☐ Iodine ☐ Shellfish

Other Medicine, Food Allergies: _____

CURRENT MEDICATIONS include prescriptions, over-the-counter, vitamins, herbals	☐ Aspirin	☐ Coumadin

ILLNESSES Please answer "yes" or "no" if you have had any of the following or are taking medications for treatment of:

Yes No		Yes No		Yes No	
☐	☐ Diabetes -How long_____	☐	☐ Blood clot in leg (DVT)	☐	☐ Murmur
☐	☐ High Blood Pressure	☐	☐ Emphysema	☐	☐ Muscular dystrophy / disease
☐	☐ Heart Attack -When_____	☐	☐ Epilepsy / seizures	☐	☐ Neuropathy
☐	☐ Pacemaker	☐	☐ Fibromyalgia	☐	☐ "Arthritis" (osteoarthritis)
☐	☐ Stroke (CVA)-When _____	☐	☐ GERD	☐	☐ Arthritis, other_____
☐	☐ Stroke (TIA)-When_____	☐	☐ GI/Rectal bleeding	☐	☐ Osteoporosis
☐	☐ Acid Reflux	☐	☐ Gout	☐	☐ Parkinson's
☐	☐ Allergies, seasonal	☐	☐ Hearing aid	☐	☐ Peripheral Arterial or Vascular Disease
☐	☐ Alzheimer's	☐	☐ Heart Disease / CAD	☐	☐ Phlebitis
☐	☐ Anemia	☐	☐ Dialysis / Hemodialysis	☐	☐ Pulmonary Embolus in Lungs
☐	☐ Angina	☐	☐ Hepatitis A	☐	☐ Raynaud's disease
☐	☐ Anxiety	☐	☐ Hepatitis B	☐	☐ Rheumatoid Arthritis
☐	☐ Arrhythmia	☐	☐ Hepatitis C	☐	☐ Sciatica
☐	☐ Artificial heart valves _____	☐	☐ HIV/AIDS	☐	☐ Sickle Cell
☐	☐ Asthma	☐	☐ High cholesterol	☐	☐ "Slipped Disc"
☐	☐ Atrial fibrillation	☐	☐ Hyperthyroid	☐	☐ Tattoos
☐	☐ Back Problems _____	☐	☐ Hypothyroid	☐	☐ Tuberculosis
☐	☐ Bleeding Disorders	☐	☐ Kidney Disease _____	☐	☐ Ulcers in stomach or intestine
☐	☐ Cancer –where _____	☐	☐ Lung Disease _____	☐	☐ Varicose veins
☐	☐ COPD	☐	☐ Lupus / SLE	☐	☐ Currently pregnant
☐	☐ Depression	☐	☐ Multiple sclerosis (MS)	☐	☐ _____

MAJOR SURGERIES, HOSPITALIZATIONS, INJURIES	SOCIAL HISTORY
	Occupation:
	Athletic activities:
	Alcohol: ☐ None _____ ounces per week
	Tobacco: ☐ None ☐ Quit _____ packs per day for _____ years
	Drug use: ☐ None _____

FAMILY HISTORY/ WHO?	☐Diabetes _____	☐Stroke _____	☐Heart Attack _____	☐Cholesterol_____
☐Rheumatoid _____	☐Lupus _____	☐High Blood Pressure _____		☐

REVIEW OF SYSTEMS Do you currently feel any of the following symptoms?			☐ NONE	☐ Chills
☐ Dizziness	☐ Headache	☐ Nausea	☐ Vomiting	☐ Fever
☐ Difficulty breathing	☐ Leg or foot swelling	☐ Calf pain when walking	☐ Leg cramps at night	☐ Cold feet or toes
☐ Chest pain	☐ "Poor circulation"	☐ Burning in the feet	☐ Numbness in the feet	☐ Spider veins