COMPREHENSIVE FOOT CARE, INC
John J. Swierzewski, DPM
PATIENT REGISTRATION

Last Name_____

First Name_____ Middle Initial_____

Street Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Work Phone_____

Birth Date_____ Age_____ Marital Status _____

Social Security# _____ Occupation _____

Employer's Name _____ Employer's Phone # _____

Whom May We Thank for Referring You to Our Office?_____

Name of Primary Care Doctor_____

Address of Primary Care Doctor_____

_____

Date of last visit to P.C.P. _____

IN CASE OF AN EMERGENCY, WHOM SHOULD WE CONTACT?

Name _____Relationship _____ Phone # _____

I hereby give permission to the doctor to release any information to my insurance company acquired in the course of my examination and treatment.

I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I accept financial responsibility for non-covered services.

I hereby give permission to the doctor to administer treatment and perform such general procedures, as he may deem necessary in the diagnosis and/or treatment of my condition.

Patient's Signature _____Date _____

WELCOME TO OUR OFFICE!

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING INCLUDING VITAMINS AND HERBAL SUPPLEMENTS

_____

_____

_____

PLEASE LIST ANY ALLERGIES_____

_____

Please list any surgeries
You have had_____

_____

Do you use tobacco products? YES_____ NO_____

YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS, **PLEASE CIRCLE**:

Diabetes	Epilepsy	Tuberculosis
Asthma	Glaucoma	High Blood Pressure
Anemia	Gout	High Cholesterol
Bleeding Tendencies	Heart Trouble	Ulcers
Kidney or Bladder Trouble	Cancer	Poor Circulation (e.g. cold feet)

Other_____