



"Put your feet in our hands"

JAMES F DONOVAN, D.P.M.

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PATIENT INFORMATION SHEET

Last Name _____ First Name _____ Middle Initial _____

Sex: Male Female

Marital Status Single Married Divorced Widowed

Address: _____ Apt: _____

_____ City _____ State _____ Zip _____

Social Security # _____ - _____ - _____ Birth Date ____/____/____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ Ext. _____

Occupation _____ Patient employed by _____
 Full time Part-time Retired

Cell Phone (____) _____ - _____

Preferred Method of Communication: Cell Phone Home Phone Work Phone Email

Email _____

Your email address is needed to send you copies of any lab work and for direct communication with the doctor.

Emergency Contact _____ Phone (____) _____ - _____
Relationship to patient: Spouse Parent Child Other _____

How were you referred to our office? _____

Who is your primary care physician? _____ Address _____

Pharmacy _____ Address _____



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NEW PATIENT INFORMATION SHEET (pg 2)

Last Name _____ First Name _____ Middle Initial _____

Medical History:

Height _____' _____" Weight _____ Last known blood pressure _____/_____ Shoe size _____

Do you have or have you ever been treated for:

- | | | | | | |
|---|---------------------------------------|---|---|---|-----------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Blood Clots/DVT | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Hearing Disorder | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Valvular Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Asthma | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Other Psychiatric Disorder | <input type="checkbox"/> GERD |
| <input type="checkbox"/> Nerve Disorder | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Alcoholism/drug dependency | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Other _____ | | <input type="checkbox"/> Other _____ | sobriety date: _____ | |

Allergies to Medications: _____

PLEASE PRINT YOUR MEDICATIONS CLEARLY *If you have a list, we'll make a photocopy*

Current Medications:	Name _____ strength _____	Name _____ strength _____
	Name _____ strength _____	Name _____ strength _____
	Name _____ strength _____	Name _____ strength _____
	Name _____ strength _____	Name _____ strength _____

Family history:

<input type="checkbox"/> Diabetes (Relationship: _____)	<input type="checkbox"/> Heart Disease (Relationship: _____)
<input type="checkbox"/> Blood Clots (Relationship: _____)	<input type="checkbox"/> Stroke (Relationship: _____)
<input type="checkbox"/> Poor Circulation (Relationship: _____)	

Social History: Tobacco use: Never Former (quit date: _____) Current _____ Amount daily

Drink Alcohol Daily: No Yes _____ Amount daily (# of drinks)

Past surgical history: _____

X

Signature of patient

Today's Date

PRINT NAME OF PATIENT



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ALL PATIENTS:

I authorize the release of information including my diagnosis and records of treatment rendered to me to my third party payers and to other health practitioners. **If I have not paid the doctor directly, I authorize my insurance benefits to be sent directly to Dr. James F. Donovan.**

I understand that my insurance carrier may pay less than the actual charge for services rendered. I agree to be responsible for the amount that is not paid by my insurance carrier for all services rendered on my behalf.

Financial arrangements: Payment is due when services are rendered unless other arrangements have been made in advance.

I understand that any balance remaining after my insurance carrier pays its share is due within thirty days. I understand that it is my responsibility to pay for any claims that are denied by my insurance for any reason. It is my responsibility to pay for amounts applied to deductibles, copayments, or coinsurance. Any balances that are over thirty days past due are subject to late charges of 10% of the amount due plus interest charges of 18% annually.

Checks returned from the bank, for any reason, are subject to a \$30.00 handling fee.

X

Signature of patient

Today's Date

H I P P A (Health Insurance Patient's Privacy Act)

Please list the names people you permit us to share your medical information with

(And information concerning your appointments and bills)

I have read and I understand the HIPPA rules concerning the health insurance portability and accountability act.

X

Signature of patient

Today's Date