

THE CENTER FOR RECONSTRUCTIVE FOOT SURGERY, P.C.
One Liberty Square
New Britain, CT 06050
860-229-2807

PATIENT INFORMATION SHEET

(Confidential Information – important for our files and your health)

PATIENT: first name _____ last name _____ DOB _____ sex M/F, AGE _____
Street address: _____ Town _____ St. _____ Zip _____
Telephone home _____ cell _____ work _____
SS# _____ Employed by: _____ Town _____
Name of Responsible Party
first: _____ Last: _____ Relationship: _____
Responsible party SS# _____ DOB: _____
In Case of emergency contact _____ phone _____
Can we call you at work? Yes/No
Name of Ins. Carrier _____ ID# _____
Name of other ins _____ ID# _____

Whom may we thank for referring you to this office: First and Last name of person referring you here:
_____ last _____ if referred by MD phone _____

What brings you to the office today? _____

MEDICAL HISTORY:

Family Doctor's first name _____ last _____ phone _____
Former Podiatrist's first name _____ last _____ phone _____
Reason you saw him/her: _____

List all medications you are currently taking _____

List any and all allergies _____

WOMEN only: Are you pregnant or do you think you could be pregnant? Yes/No

Indicate which of your immediate relative have had any of the following diseases:

Cancer _____ Diabetes _____
Heart Trouble _____ High Blood Pressure _____
Kidney Disease _____ Mental/Emotional Disease _____
Stroke _____ Arthritis _____

Please give details of any:

OPERATIONS/SERIOUS INJURIES	APPROX. DATE	PHYSICIAN	HOSPITAL

Have you previously had physical therapy? _____

When? _____

Where? _____

For What Condition? _____

Is there anything you wish to tell the physician privately? _____

Do you have any allergies to medications _____,

Foods _____ other _____.

Patient Signature _____ Date _____

I hereby authorize the release of medical information to my insurance carrier concerning my illness and treatment and I hereby assign to Dr. Jolly a/o The Center for Reconstructive Foot Surgery, P.C., all payments for medical services rendered to me or my dependent. I understand I am responsible for any amount not covered by my insurance.

Signature of patient or guardian _____

Date _____