Dr. Steven J. Repitor - Podiatrist

Physician and Surgeon of the Foot/Ankle

Date _____ Date of Birth _____ S M W D Sex: M F

Patient's Name _____ Social Security Number _____

Address _____ City _____ Zip Code _____

Home Phone _____ Business Phone _____ Cell Phone _____

Email _____

Person to Contact in Case of Emergency _____ Phone _____

Family Physician _____

Cardiologist _____

Pharmacy _____ Address _____ Phone _____

INSURANCE INFORMATION:

Name on Insurance Card: _____ Self Spouse Dependent

BCBS: Contract # _____ Group # _____ Service Code _____

MEDICARE # _____ MEDICAID # _____

PRIVATE: Billing Address _____

Company _____ Policy # _____ Phone # _____

MEDICAL INFORMATION:

Height _____ Weight _____ Shoe Size _____

ALLERGIES: I am allergic to: (Please Check)

_____Penicillin _____Sulfa _____Iodine _____Other _____

_____Codiene _____Adhesive Tape _____Latex _____I have no known allergies

MEDICAL HISTORY: (Please Check)

_____Diabetes _____Heart Disease _____Stroke _____High Blood Pressure

_____Blood Clots _____Kidney Disease _____Liver Disease _____Stomach Problems

_____Sickle Cell Anemia _____Eye Disease _____Cancer (Type) _____

_____Heart Attack or Chest Pains in the past six months ❒ Yes ❒ No

_____No Current Medical Problems _____Other _____

FAMILY MEDICAL HISTORY: (Please Check)

_____Diabetes _____Heart Disease _____Stroke _____High Blood Pressure

_____Blood Clots _____Kidney Disease _____Liver Disease _____Stomach Problems

_____Sickle Cell Anemia _____Eye Disease _____Cancer _____

_____Other _____

CURRENT MEDICATIONS: (List) ❒ No Current Meds _____

_____

_____

PAST SURGERIES: (List) ❒ None _____

_____

SOCIAL HABITS: (Please Check)

_____smoker _____packs per day _____years smoking _____non-smoker

_____stopped smoking, when _____

_____alcohol use _____socially _____drinks per week _____none

_____drug use

REFERRED TO OFFICE BY: _____

I hereby give permission to Dr. Repitor and/or his associates to examine and treat my foot and/or ankle condition. I also authorize the release of any medical information necessary to process this claim and request payment of health care benefits to this office for my treatment. Additionally, I agree to pay any non-covered services or deductible and co-payment required by my health insurance policy.

Date: _____ _____

Signature of patient - Parent / Guardian /Caregiver

REV. 11-15