Scott M. Aronson, D.P.M., P.C.

PODIATRIC MEDICINE AND SURGERY

PATIENT INFORMATION SUMMARY

Name: (first)__________________(last)_________________________(middle initial)_____
Address: (street)________________________(city)________________(state)_____(zip)______
Phone (Home): (_____)_______-________ Phone (Business): (_____)_______-________
E-mail Address: ____
Date of Birth: ___/___/___ Height: _____ Weight: ____ Sex: ***M/F*** Marital Status: ***S/M/D/W***
S.S. #:_____-_____-_____ Employer: ________________ Occupation:_____________

PRIMARY CARE PHYSICIAN: ____
Address:
(street)________________________(city)________________(state)_____(zip)_______
Phone: (_____)_______-_________ Fax: (_____)_______-________

PHARMACY USED: _________________________Phone: (_____)_______-________

INSURANCE INFORMATION

(*Please provide us with your insurance card and picture identification)

Medicare / Tufts / BCBS / HPHC / Other _________________ Co-payment $: ______
Relationship to Subscriber: ***Self/Dependent/Spouse: (Name: _________________D.O.B:___/___/___)***

MEDICAL HISTORY *(*may list on separate sheet*)

Do YOU have a history of any of the following:

[] Diabetes [] High BP [] Heart Disease [] Liver Disease [] Drug Use/Abuse
[] Arthritis [] Anemia [] Bleeding Disorder [] Cancer:________ [] Alcohol Use
[] Hepatitis [] Asthma [] Rheumatic Fever [] Gout [] Smoking
[] HIV/AIDS [] Epilepsy [] Artificial Joint [] Tuberculosis [] Ankle Sprains

Do you have a FAMILY HISTORY of any of the following:

[] Diabetes [] High BP [] Heart Disease [] Liver Disease [] Blood clots
[] Arthritis [] Anemia [] Bleeding Disorder [] Cancer [] Gout

ALLERGIES:

[] Penicillin [] Local Anesthetic [] Aspirin [] Adhesive Tape [] Sulfur [] Other _________________

Current MEDICATIONS: ____
____
____
____

Past SURGERIES: ____
____

Date of Last Complete Physical Exam: ___/___/___ by Dr.____________________
Last visit to a Podiatrist: ___/___/___ Reason: __________________________________
____
REASON FOR TODAY'S VISIT: ____
____
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE:
[] Dr. ______________________ [] Insurance Plan [] Advertisement______________ [] Phonebook
[] Internet [] Friend____________[] Hospital/E.D. [] Family Member _____________