Long Lake Podiatry, P.C.
David H. Berlin, DPM
Board Certified Surgeon

Today's Date: _____

Welcome To Our Office

Name: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Birth date: _____

Home Phone #: _____ Cell/Alt #: _____

Can we leave voice messages? yes no Can we send text messages to your cell phone? yes no

Email: _____ How did you hear about us? _____

Marital Status: S M D W Spouse's name: _____

Your Employer: _____ Name of Insurance: _____

IF DIFFERENT FROM ABOVE

Insured Name: _____ Insured Birth date: _____

Insured Employer: _____ Insured Social Security#: _____

Emergency Contact Name: _____

Emergency Contact #: _____ Relation to you: _____

What is your preferred language? _____

Ethnicity ? ○ Hispanic or Latino
○ Not Hispanic or Latino

Race? ○ African or African American
○ Asian or Asian American
○ Caucasian or European American
○ Native American or Native Alaskan
○ Native Hawaiian or Other Pacific Islander
○ Other race _____

Are you a current smoker? ..... ○ No
○ Yes... How much? _____

Are you a former smoker ..... ○ No
○ Yes... When did you quit?_____ How long did you smoke?_____

Do you drink alcohol? ..... ○ No
○ Yes... How much? _____

Do you bruise easily? ..... ○ No ○ Yes

Do you have back pain? ..... ○ No ○ Yes

Are you subject to prolonged
bleeding or delayed healing?.... ○ No ○ Yes

Any possibility your pregnant?.. ○ No ○ Yes

Height: _____ Weight: _____ Shoe Size: _____

When was your last tetanus shot? _____

What is your major complaint today?

○ Pain	○ Injury	○ Wart	○ Diabetic Check
○ Corn	○ Bunion	○ Hammertoe	○ Ingrown Toenail
○ Mass	○ Swelling	○ Toenail Fungus	○ Skin Disorder
○ Tough Toenails		○ Other _____	

Location of your complaint?

Ankle:	○R	○L	Arch:	○R	○L
Ball:	○R	○L	Heel:	○R	○L
Top of Foot:	○R	○L	Toe(s):	○R	○L

Other _____

How long have you had this problem? _____

Have you been treated in the past for this problem? ○ No ○ Yes If yes, by whom? _____

If yes, what was the treatment? _____

_____

ALLERGIES AND REACTIONS

ALLERGY	REACTION
○ Adhesives	
○ Antihistamines	
○ Aspirin	
○ Betadine	
○ Codeine	
○ Cortisone	
○ Latex	
○ Penicillin	
○ Sulfa	
○ Tylenol	
○ Xylocaine	
○ **OTHER**	
○	
○	
○ **I HAVE NO ALLERGIES**	

MEDICATIONS

MEDICATION	DOSE	TIMES/DAY

MEDICAL CONDITIONS

ME	FAMILY	YEAR	
○	○		Rheumatoid Arthritis
○	○		Osteoarthritis
○	○		Artificial Hip / Right or Left?
○	○		Artificial Knee / Right or Left?
○	○		Sciatica
○	○		Low Blood Pressure
○	○		High Blood Pressure
○	○		Active Cancer: type?_____
○	○		Cancer in remission: type?_____
○	○		Anemia
○	○		Aneurysm
○	○		Bleed Easily
○	○		Blood Clots
○	○		Hemophilia
○	○		Peripheral Vascular/Artery Disease
○	○		Venous Insufficiency
○	○		Phlebitis
○	○		Varicose Veins
○	○		Asthma
○	○		COPD
○	○		Emphysema
○	○		Tuberculosis
○	○		Eczema
○	○		Excessive Perspiration
○	○		Psoriasis
○	○		Warts

ME	FAMILY	YEAR	
○	○		Diabetes
○	○		Do you take Insulin?
○	○		Angina
○	○		Arteriosclerosis
○	○		Chronic Heart Failure (CHF)
○	○		Mitral Valve Prolapse
○	○		Myocardial Infarction
○	○		Pacemaker
○	○		Heart Attack
○	○		Stents
○	○		Hepatitis: Type? A B C
○	○		AIDS/HIV
○	○		Any communicable disease
○	○		Fibromyalgia
○	○		Lupus
○	○		Gullian Barre
○	○		Multiple Sclerosis
○	○		Parkinson
○	○		Polio
○	○		Sickle Cell and Trait
○	○		Stroke
○	○		Neuropathy
○	○		Underactive Thyroid
○	○		Overactive Thyroid
○	○		
○	○		

PLEASE LIST ALL SURGERIES AND DATE PERFORMED

_____

_____

_____

_____

Primary Care Physician's Name: _____

Physician's Address:_____

Phone#:_____

Pharmacy Name: _____

Phone#:_____

Pharmacy Address or crossroads:_____

Is there anything else we should know?_____

I hereby authorize assignment of benefits to be paid directly to Dr. David H. Berlin, DPM. This assignment will remain in effect until revoked by me in writing. I understand I am responsible for obtaining all needed referrals. I also agree to pay, in full, all fees regardless of insurance coverage; including deductible, co-insurance costs and any services which are determined to be "not covered" or "denied". I give Dr. Berlin permission to release any information requested by my insurance in the course of my treatment. I also give permission for Dr. Berlin, DPM to perform such general procedures as he may deem necessary in the diagnosis and treatment of my condition. A photocopy of this agreement shall be considered valid as an original.

Patient / Guardian Signature:_____

Date:_____