ANKLE & FOOT CLINIC
Kent DiNucci, DPM
8625 Q Street
Omaha, Nebraska 68127

Please print the following information:

Patient's full legal name_____ **Date of Birth**_____ **Age**_____

Patient's Street Address _____ **M**____ **F**_____

City_____ **State**_____ **Zip Code**_____

Home Phone ( ) _____**Work Phone ( )** _____**Cell Phone ( )** _____

Marital Status _____ **E-mail**_____

Family Physician_____ **Physician's Phone #**_____

Referring Physician _____ **Pharmacy** _____

Emergency Contact _____ **Phone #** _____ **Relationship** _____

*****Referred to our office by: Physician** ___ **Friend/Family** _____ **Phone Book** ____**Other**_____

Patient's Employer _____**Full Time Student: Yes**_____ **No**____

Employer's Address _____ **Occupation** _____

****

IF MARRIED:

Spouse's Name_____ **Date of Birth** _____

Employer _____ **Work Phone** _____

Employer's Address _____

****

MINOR OR STUDENT

Father's name _____ **Date of Birth** _____

Father's address if different than patient's _____

Father's employer_____ **Work Phone** _____

Mother's name _____ **Date of Birth** _____

Mother's address (if different than patient's) _____

Mother's employer _____ **Work Phone** _____

Insurance Information:

Primary Insurance Company _____

Policy Number _____ **Group #** _____

Who is the primary insured?_____ **Primary Insured's Date of Birth**_____

Relationship to patient _____

Secondary Insurance Company _____

Policy Number_____ **Group #**_____

Who is the primary insured? _____**Primary Insured's Date of Birth** _____

Relationship to patient _____

<u>All Patient's</u>

Are you seeing the doctor for any injury related to a car accident? **Yes** _____ **No** _____

Are you seeing the doctor for a work related injury? **Yes** _____ **No** _____

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I understand I am financially responsible for all charges not covered by insurance. I hereby assign my insurance benefits to be paid directly to Dr. Kent DiNucci, DMP, of Ankle and Foot Clinic. I also authorize Dr. DiNucci to release any information requested by my insurance company. I understand that I am ultimately responsible for paying this bill. I also understand that the above information concerning my condition will be used for filing insurance reports. I certify all the information to be true and complete.

_____ _____

Signature **Date**

ANKLE & FOOT CLINIC

Kent R. DiNucci, DPM
8625 Q Street – Omaha, NE 68127

PATIENT'S NAME _____ DATE _____

FOOT PROBLEM OR SYMPTOMS:

_____

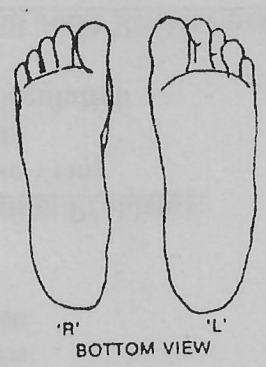
_____

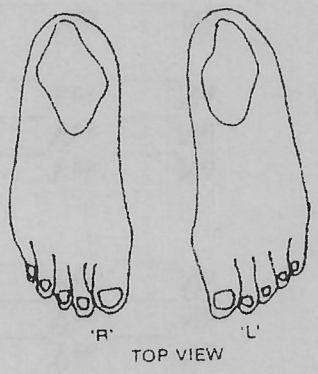
_____

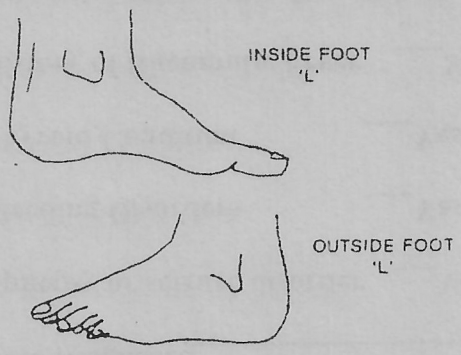
_____

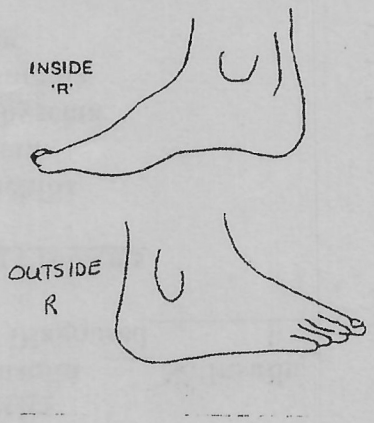
_____

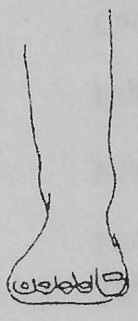
HOW LONG HAVE YOU HAD THIS PROBLEM? _____

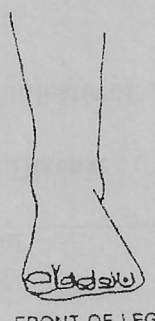


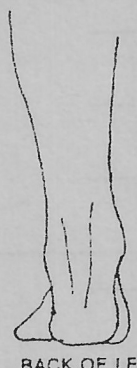












_____

_____

_____

_____

_____

_____

Initials_____ Date_____
Initials _____ Date_____
Initials _____Date_____

General Medical information
Have you ever had problems with, or have needed to see a doctor for:

Heart Problems: ____Yes ___No
___Stroke Date_____
___Mitral Valve Prolapse Date_____
___Heart Attack Date_____

Diabetes ___Yes ____No
___Insulin ___ No Insulin
Date Diagnosed_____

Lung Problems

Bronchitis ____Yes ____No
Asthma ____Yes ____No
Emphysema ____Yes ____No
Pneumonia ____Yes ____No
Other ____Yes ____No

Liver Problems
Hepatitis ____Yes ____No
Jaundice ____Yes ____No
Other ____Yes ____No

Circulation Problems:
Varicose Veins ____Yes ____No
Phlebitis ____Yes ____No
Poor Circulation ____Yes ____No

Artificial Joint Replacement ____Yes ____No
List joint(s)_____
Date _____

High Blood Pressure ___Yes ____No

Ulcers – Stomach ___Yes ____No

Ulcers – Foot/Leg ___Yes ____No

Arthritis ___Yes ____No
Location _____

Kidney Disease ___Yes ____No

High Cholesterol ___Yes ____No

Cancer: ___Yes ____No
Type_____
Date Diagnosed_____

Epilepsy or seizure disorder ___Yes ____No

Bleeding Disorders ___Yes ____No

Thyroid Condition ___Yes ____No

History of Rheumatic Fever ___Yes ____No

Other (i.e. HIV/AIDS, Hepatitis C) _____
_____

SHOE SIZE_____ HEIGHT_____ WEIGHT_____
LIST ALL ALLERGIES _____
ARE YOU ALLERGIC TO LATEX? _____
ARE YOU ALLERGIC TO ANY METAL? (JEWELRY, NICKEL?)_____
LIST ANY SURGERIES WITH DATES _____
_____
_____

PLEASE LIST MEDICATIONS OR PROVIDE US WITH A LIST_____
_____
_____
_____

HAVE YOU EVER SMOKED? _____AGE STARTED SMOKING _____
IF YES, HOW MUCH_____ DATE QUIT _____