Dr. David R. Basch, D.P.M., P.C.

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Diplomate American Board of Podiatric Surgery
Fellow International Society of Podiatric Laser Surgery

TODAY'S DATE_____

PATIENT INFORMATION SHEET

PATIENT NAME_____AGE_____BIRTHDATE_____

STREET ADDRESS_____

CITY_____ZIP_____

PHONE_____SOCIAL SECURITY #_____

(circle one) SINGLE MARRIED WIDOW DIVORCED CHILD

NEAREST RELATIVE OTHER THAN SPOUSE OR PARENT IN CASE OF AN EMERGENCY_____PHONE_____

PATIENT EMPLOYER_____

ADDRESS_____PHONE_____

POLICY HOLDER EMPLOYER_____PHONE_____

TYPE OF INSURANCE:_____

RESPONSIBLE PARTY: SPOUSE PARENT SELF

POLICY HOLDERS NAME_____

POLICY HOLDER SOCIAL SECURITY#_____DOB_____

SECONDARY POLICY HOLDER NAME_____

SECONDARY POLICY SOCIAL SECURITY #_____DOB_____

HOW DID YOU FIND OUT ABOUT DR.BASCH_____

I authorize the release of any medical information necessary to process any insurance claims and request payment of benefits be made directly to DAVID R BASCH DPM.

SIGNATURE OF PATIENT:_____DATE_____

WITNESS:_____DATE_____

PLEASE FILL OUT BOTH SIDES. THANK YOU!

PATIENT HISTORY

AGE:_____ SEX: _____ HEIGHT: _____ WEIGHT:_____
HAS THERE BEEN ANY CHANGE IN YOUR HEALTH WITHIN THE PAST YEAR? YES or NO

DATE OF LAST PHYSICAL EXAMINATION: _____
(A) NAME OF YOUR PHYSICIAN: _____
(B) ADDRESS AND PHONE #: _____
(C) ARE YOU NOW UNDER HIS/HER CARE? YES or NO

ARE YOU BEING TREATED FOR ANY OTHER CONDITIONS? YES or NO
If yes, please explain: _____

HAVE YOU BEEN HOSPITALIZED OR HAD A SEVERE ILLNESS WITHIN THE PAST FIVE YEARS? YES or NO
If yes, what was the problem? _____

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO:
YES or NO -- LOCAL ANESTHETICS (NOVOCAINE)
YES or NO -- PENICILLIN OR OTHER ANTIBIOTICS
YES or NO -- TRANQUILIZERS OR SLEEPING PILLS
YES or NO -- CODEINE OR OTHER PAIN MEDICATION
YES or NO -- ASPIRIN
YES or NO -- OTHER (PLEASE BE SPECIFIC) _____

HAVE YOU HAD ABNORMAL BLEEDING ASSOCIATED WITH SURGERY, CUTS, OR TRAUMA? YES or NO

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING:
-- RHEUMATIC FEVER/RHEUMATIC HEART DISEASE
-- ABNORMAL HEART CONDITION, if yes, please explain:_____
-- ABNORMAL BLOOD PRESSURE, if yes, HIGH or LOW
-- DIABETES OR A HISTORY OF DIABETES IN THE FAMILY
-- HEPATITIS, JAUNDICE OR LIVER DISEASE
-- RHEUMATOID ARTHRITIS (PAINFUL, SWOLLEN JOINTS)
-- ALLERGIES (OTHER THAN MEDICATIONS)

-- SINUS CONDITION
-- FAINTING SPELLS
-- STOMACH ULCERS
-- VENEREAL DISEASE
-- HISTORY OF CANCER
-- HIVES OR SKIN RASH
-- SEIZURES (EPILEPSY)
-- KIDNEY DISORDERS
-- ANEMIA
-- OTHER (PLEASE EXPLAIN:)

ARE YOU TAKING ANY MEDICATIONS: YES or NO
-- BLOOD THINNERS
-- WATER PILLS
-- TRANQUILIZERS
-- ASPIRIN OR TYLENOL
-- NITROGLYCERIN
-- MEDICINE FOR HIGH BLOOD PRESSURE
-- CORTISONE
-- ANTIHISTAMINES
-- INSULIN
-- OTHER (PLEASE BE SPECIFIC): _____

DO YOU GET LEG CRAMPS OR NUMBNESS IN YOUR FEET/TOES: YES/NO
IF A WOMAN, ARE YOU PREGNANT? YES or NO
ARE YOU A SMOKER? YES or NO